	RS FOR MEDICAR OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CO	DNSTRUCTION	OMB N	D: 05/17/ M APPRO O. 0938-
		, , , , , , , , , , , , , , , , , , ,	A. BUILD		THE THOU	(X3) DATE	SURVEY
NAME OF PE	ROVIDER OR SUPPLIER	445476	B. WING	1		John	CELED
						05	/06/2011
(X4) ID	ST HEALTHCARE S				DDRESS, CITY, STATE, ZIP CODE	Ē	50/2011
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING	I ID	MOXV	ILLE, TN 37920		
		THIS INFORMATION)	PREFIX TAG	CI	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION IOULD BE PROPRIATE	COMPLET DATE
F 000   II	NITIAL COMMENT	S			<u> </u>		
The score of score to re	790, TN27994 and F-157, F-281, F-33 ope and severity of nificant narcotic menotify the physician sident #20) of thirty facility's failure to ignificant medications serious injury, hersident #20.	an annual Recertification tion of complaints #s TN TN27457 were completed.  With an Immediate Jeopardy and F-490, all with a a "J", for failing to prevent edication errors and failing of the errors for one residents reviewed. ensure residents were free ons errors was likely to arm, impairment or death	F 000	This F requir facility Correct admiss that the the sco correct admiss Plan of the faci	Plan of Correction is submitted under State and Federa y's submission of the Plan ection does not constitute and sion on the part of the facility e findings cited are accurated ings constitute a deficiency pe and severity determinate. Because the facility make ions, the statements made Correction cannot be used lity in any subsequent strative or civil proceeding	al law. The of n lity ate, that cy, or that tion is es no such in the d against	
The A Cons Jeopa	Administrator and to	ne Corporate Nurse ed of the Immediate 1 at 12:05 p.m. in the		lme acc	ndled POC #2		
The In Februa accept remove receive	nmediate Jeopardy ary 22, 2011 throug able Allegation of (	i trie Jeopardy, was					
Non-co	mpliance of the I-	mediate Jeopardy tags	1				
The faci	lity is required to su on for all tags. ()(11) NOTIFY OF	ıbmit a plan of		157 Resider	nt #20 is no longer at the fac	sility	
Y DIRECTOR	SOP PROVIDE	CHANGES F	41	24/11.			
MI	OK PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGNATURE	1	7.7	Tifle		
ipation.	ending with an asterisk sufficient protection to the whether or not a plan se documents are made	(*) denotes a deficiency which the in- ne patients. (See instructions.) Exce- of correction is provided. For nursing e available to the facility. If deficience	stitution may be for nursing homes, the idea are cited,	be excus	Hada	s determined to sclosable 90 d re disclosable ite to continue	<u></u>
7(02-99) Previo	ous Versions Obsolete	Event ID: ZTPW11	01902		(madd 6/	2/11	
			Facility ID: TN4	4706	JUN 03 20 Prontinuation	sheet Page 1	of 43

CENT	ERS FOR MEDICA	AND HUMAN SERVICE	S				PRINTE	D: 05/17/201
	ERS FOR MEDICARE	<u> MEC ID SERVICES</u>	3				FOR	MAPPROVER
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2	MIII TIE	DIECO	NSTRUCTION	OWR M	O. 0938-0391
1		IDENTIFICATION NUMBER:		BUILDING		MOCHON	(X3) DATE	SURVEY
1					,		COMP	LETED
NAME OF	PROVIDER OR SUPPLIER	445476	B. V	MING			l	
				CTD			05/	06/2011
HILLCR	REST HEALTHCARE SO	ОИТН		17.	ET AL	DRESS, CITY, STATE, ZIP CODE		
				1 "	20 LII	LWOOD DRIVE		
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES			10XV	ILLE, TN 37920		
TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL CONTROL IN THE PRECEDED BY FULL CONTROL INFORMATION)	PRE			PROVIDER'S PLAN OF CORRECT	TION	(X5)
		THE IN ORMATION)	TA	G	CI	(EACH CORRECTIVE ACTION SHOUR ROSS-REFERENCED TO THE APPRI	JLD BE OPRIATE	COMPLETION DATE
F 455						DEFICIENCY)	JI KINIE	DATE
F 157	I I I I I DAN	e 1				1		
SS=J	(INJURY/DECLINE/F	ROOM ETC)	F	157	T-1			1 1
					The p	hysician was notified of medic	ation	
	A facility must immed	liately inform the resident;			error	on 2/24/11 by the Director of N	Jursing.	1 1
	consult with the resid	ent's physician; and if		1				1 1
1			_ 1		on 3//	nistrator educated Director of	Vursing	1
İ	accident invested family	dent's legal representative y member when there is a	in		arco	1/11 on the Policies and Proced	ures for	1 1
	injury and has the	y member when there is a resident which results in	"	t	he in	tic counts, notification of change cident event management process	ge, and	
1	intervention: a significant	resident which results in ential for requiring physici	an	- 1		and event management proce	dure.	
1	physical mental or a	ant change in the resident	t's	1	An inv	vestigation'was begun by the D	:	
1	deterioration in hootth	sychosocial status (i.e., a		0	f Nu	sing on 3/4/11.	nector	
:	status in either life thre	eatening condition	1	li li		*	.	
(	clinical complications):	a need to alter treatment		T	he Pl	narmacy Consultant was notifie	dofthe	1
.   8	significantly (i.e., a necessiting form of treatments	ed to discontinue or		1 11	icaica	ation error on 3/2/11 and was :		- 1
6	existing form of treatm	ent due to adverse		Ir	the i	nvestigation of narcotic count	error.	l
	consequences, or to co	ommence a new form of		1			- E	
1	he resident for a decision	ommence a new form of on to transfer or discharge		L	EIN #.	2 is no longer employed as of 3	/19/11.	1
8	he resident from the fa 483.12(a).	acility as specified in					0.40	
1	******	9		m	edica	udit of 100% of the liquid narc tion sheets was done by the Di	otic	- 1
T	he facility must also no	romptly notify the resident		of	Nurs	sing on 3/4/11. No other resider	rector	1
a	nd, if known, the reside	romptly notify the resident ent's legal representative		ide	entifi	ed as being affected.	its were	- 1
or	interested family men	nher when there i	1	1				
ch	nange in room or room pecified in \$483 15(a)	mate assignment of		Al	l liqu	id narcotics records were revie	wed by	
sp	pecified in §483.15(e)(sident rights under Fo	(2); or a change in		-	TUE	ivital Director of Clinical Came		
re	sident rights under Fed	deral or State law or		un	u a IX	Egistered Niirge on 5/4/11 Nr.	other	
	s section.	in paragraph (b)(1) of		les	ident	s were found to be affected.		2.
""	o occion.	And Control of the State of the		3.1	nsers	rice was given to 11 1		1
Th	e facility must record a			stat	ffon	vice was given to all licensed no 3/4/11 - 3/10/11 by Director of	ırsing	
		and periodically update umber of the resident's		Nui	rsing	regarding measuring narcotic l		
leg	al representative or in	terested family member.		with	h retu	rn demonstration required.	iquids	
		terested family member.			9	anon required.		1
	U-22_22						- 1	1
This	S REQUIREMENT is	not met as evidenced		1				1
, ~y.								
Bas	sed on facility policy re	eview, review of a			57			
Ivar	cotic Count Sheet, me	dical record review.	100					1.
<del></del>			1		12.12			

I CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 2 of 43

TATEME	NT OF DEFICIENCE					FOR	D: 05/17/20 M APPROV
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE C	ONSTRUCTION	OWR M	<u>0. 0938-03</u>
		SATION NOMBER:	A. BUILO		SHOTHOO HON	(X3) DATE	SURVEY LETED
		445476	B. WING			COMP	re LED
AME OF	PROVIDER OR SUPPLIER	110470				05	0010-
HILLCR	REST HEALTHCARE S	OUTH	s	TREET A	DDRESS, CITY, STATE, ZIP COL		06/2011
			1	1130 11	LLWOOD DRIVE	- <del></del> -	
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	T	KNOX	/ILLE, TN 37920		
TAG	REGULATORY OR L	A LEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX	1	PROVIDER'S PLAN OF CORE	RECTION	ME
		THO INFORMATION)	TAG	C	ROSS-REFERENCED TO THE A		COMPLETIC DATE
F 157	Co-4:			1	DEFICIENCY)		DATE
. 107	, and a light had	ge 2	F 455	. Med	lity policy on Administering ications was revised by Adr	Controlled	
	interview of the Medic	ation Occurrence Report, and	F 157	and	Director of Nursing on 5/4/1	ninistrator	
- 1	when sizes	failed to notify the physician		that	two nurses verify and sign of	off on the	
l	resident (#20)	edication errors for one		IVICU	Ication Administration Reco	rd all liquid	
j	reviewed The facility	red of thirty-one residents		liai C	out doses less than 5ml Or	5/6/11 +4:-	
- 1	physician of significant	y's failure to notify the		IEVIS	ion was added to the parcet	ic mad	M.
	likely to cause serior	int medication errors was injury, harm, impairment,		Ponc	y allu lyled Pass ()hservation	n choot he.	
- 1	or death to resident	20 Harm, Impairment,	- 5	the I	egional Director of Clinical	Comicas	
1				and S	igned by the Administrator	and Director	
13	On May 4, 12:05 p.m	., in the office of the		OI IN	rsing.		
				All li	censed nurses were - 1	1	
1.	Jeopardy.	informed of the Immediate		Regio	censed nurses were educated and Director of Clinical Ser	d by	
1	ocopardy.	odiate		Direc	tor of Nursing and Admission	vices,	
1	The findings included:			on 5/4	$\frac{1}{11} - \frac{5}{20}/11$ on the follow	ons Nurse	
1	included:			requir	ements: verification of any	lianid	
R	Resident #20 was adm	nitted to the facility with		naico	it less than 5 mls by a secon	nd nurse	
di	iagnoses including D	iabetes Type II, reoccurring		WIIO II	lust also initial Medication		
C	ongestive Heart Failu	ure, Chronic Obstructive	1	Admii	histration Record Inservice	s also	
P	ulmonary Disease/Ox	Gygen-Dependent, Morbid		merud	ed the Five Rights of Medic	ation	
G	besity, Chronic Anemastro-Intestinal Blood	nia related to slow	- 1	Aumin	IISITATION, alert charting to b	a imitiat - 1	
blo	astro-intestinal Bleed	ing requiring intermittent		medica	ry shift for seventy-two hou	rs after a	
an	d Liver Failure with p	nentia with Depression,	1	Physic	ation error, timely notification in Director of Nursing and	on of the	
	December 2010.	mentia with Depression, blood Disorder diagnosed		Admin	istrator after a medication e	the rror	
1						- S	
Re	view of the nurse's pe	rogress notes for		The Me	edical Director and Pharmac	ev	1
				Consul	tant will be advised by the		- 1
"8	Spoke with (names o	f two sons) Total	1	Admin	Istrator or the Director of No	arsing of	- 1
			1	any me	ulcation administration erro	r and will	- 1
Atro	er for MSO4 (morphi	ne, a narcotic) and	1	oe men	ided in the investigation pro	0000	1
Auc	opine (decreases sec	retions)Will monitor."		Improv	the Quality Assurance Perfement process.	ormance	
Rev	iew of the physician			mpi O v	ement process.		1
201	riew of the physician's	orders for February			1 W 81 Sta	ļ	- 1
Rox	anol (a liquid mombin	ry 19, 2011, an order for					
(milli	igram) PO (by mouth	ny 19, 2011, an order for ne preparation) 1-2 mg ) q 1 (every one) hour	F .			1	
PRN	(as needed).	y i (every one) hour					
				7			- 1
	9) Previous Versions Obsolete					· · · · · · · · · · · · · · · · · · ·	- 1

#### DEPARTMENT OF HEALTH AND H" "MAN SERVICES CENTERS FOR MEDICARE & MEL PRINTED: 05/17/201 **AID SERVICES** STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 445476 B. WING NAME OF PROVIDER OR SUPPLIER 05/06/2011 HILLCREST HEALTHCARE SOUTH STREET ADDRESS, CITY, STATE, ZIP CODE 1758 HILLWOOD DRIVE (X4) ID PREFIX KNOXVILLE, TN 37920 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION TAG **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 157 Continued From page 3 F 157 4. Daily monitoring by a Registered Nurse Record review of the third Narcotic Count Sheet for two weeks, beginning May 5, 2011 dated February 20, 2011, (used to record each through May 19, 2011, then two times a week. narcotic dose administered) for liquid morphine for three months until August 18, 2011 and/or for resident #20 revealed a sticker-type label until 100% compliant, to include a 100% adhered to the top right of the sheet with the audit of Medication Error Sheets for proper following information included: "(resident #20's notification of Physician, Administrator, and name); room # (number); MORPHINE SULFATE Director of Nursing; a 100% audit of the 100 MG/5 ML (milliliter) substituted for Medication Administration Records of ROXANOL 20 MG/ML SOLUTION; residents receiving liquid narcotic doses less 02/19/11(date); Take 0.05ML-0.1ML (1-2MG) than 5 milliliters to ensure compliance of two EVERY HOUR AS NEEDED; QTY (quantity) 30 nurses verifying the dose and signing the ML.(total dispensed from the pharmacy)" Medication Administration Record; and auditing of the alert charting log against the Interview at 10:00 a.m., on May 3, 2011, in the medication error reports to verify alert conference room with the Director of Nurses charting compliance for 72 hours. (DON) revealed the following: The Regional Director of Clinical Services 1) the narcotic count was incorrect at 3:00 p.m., will perform a compliance review of 100% of February 23, 2011, with less liquid narcotic the audit forms and related data weekly until remaining than on the Narcotic Count Sheet the end of the monitoring time. record: 2) the DON did not investigate the discrepancy in All audit results will be reported by the the narcotic count: Director of Nursing to the monthly Quality 3) the DON changed the amount left to count; Assurance Performance Improvement 4) on February 23, 2011, the DON interviewed meetings for review and recommendations. the 11-7 (night shift) Licensed Practical Nurse This committee will determine if any (LPN #2) and LPN #2 stated the resident had revisions are needed to the audit plan. been given 1 ml (20 mg of morphine instead of 2 mg) at 1:00 a.m., 3:00 a.m., and 5 a.m., on February 22, 2011; 5) the DON stated knowledge of the day shift LPN #1 giving two additional 1.0 ml doses of morphine instead of 0.1 ml (20 mg of morphine instead of 2 mg) on February 22, 2011 at 7:00 a.m. and 11:00 a.m. The DON did not define a timeframe for when the DON realized the resident had received a total of five incorrect doses on

	ERS FOR MEDICAR  ENT OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIED/OUT	Iva	A## ====		FOR	D: 05/17/20 RM APPROV O. 0938-03
		IDENTIFICATION NUMBER:	(A. B	MULTIPLE ( JILDING	CONSTRUCTION	(X3) DATE	SURVEY PLETED
IAME OF	PROVIDER OR SUPPLIER	445476	В. И	ING			CCIED
			·	STREET	ADDRESS OF	05	/06/2011
	REST HEALTHCARE S	НТИС		1	ADDRESS, CITY, STATE, ZIP C	ODE	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		KNOX	VILLE, TN 37920		
TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	1X	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		(X5) COMPLETIO DATE
F 157	I I I DON'T DAY	ne 4			JEI IOIENCY)		
	February 22, 2011.	, c 4	F	57 The	Quality Assurance Perform	mance	
	E			Impr	rovement Committee cons	ists of	
	the irreconcileble par	the DON had not considered		Nurs	inistrator, Medical Directing, Assistant Director of	or, Director of	
- 1	medication error and	ne DON had not considered cotic count as a significant did not notify the physician.		Hum	an Resources. Minimum 1	Data Set	1
	Povious su	and not notify the physician.		COOL	umator, Treatment Nurse	Admissions	
	Review of the facility's	s policy 'Medication	1	Diffe	tor, Business Office Man	ager Dobob	ľ
16	event of a significant	Procedures: a. In the		Facili	nger, Medical Records, So ities Management Directo	cial Services,	ž0.
16	errorimmediate acti			Ivialia	iger, and Activity Director	Distinion and	
1	to protect the resident	on is taken, as necessary, s safety and welfare. b.		1 Hall	nacist reports are reviewed	d and 41	41.,
7	The physician's order	in is flouried promptlyc.	1776	consu	ltants attend as needed.		5/26/11
d	esident is monitored of lirected."	an is notified promptlyc. are implemented, and the closely for 24 to 72 hours as					
in	decord review of a 'Me deport' revealed the M formed of the significa debruary 24, 2011.	edication Occurrence edical Director was ant medication error on					22
1	10 188 48 TO 1970 10 (15 TO 1)				0.0	1	
no	t followed the facility	1, in the conference room. n., verified the DON had				4	
occ	ysician when the sign curred.	ficant medication error	1				
Cor	ntinued interview conf	irmed on February 22,			**		
201	1, in a 10 hour period	rmed on February 22, resident #20 received					
and	mg of morphine insta the physician was no	ead of the ordered 10 mg t notified.					.
The	Immediate Jeopardy	Was offonting for			3 8 a 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	**	3 .
Febr	ruary 22, 2011, through	th May 6, 2011 and					
Allen	removed on May 6, 2	011. An acceptable					
imme	ediacy of the jeonard	which removed the					
corre	ective actions were va	lidated on site by the					.
	The state of the s	OIL OILE DY (IIE	- E		4		- 1

	- CIVIVILLDICAR	H AND HI " IAN SERVICES  B & MEDID SERVICES				PRINTED	0: 05/17/201 APPROVE
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)	MULTIPLE	CONSTRUCTION	(X3) DATE S	). 0938-039 SURVEY
NAME OF	PROVIDER OR SUPPLIER	445476		/ING		COMPL	ETED
HILLCR	REST HEALTHCARE S	OUTH		1 11301	ADDRESS, CITY, STATE, ZIP C	05/0	06/2011
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI		PROVIDER'S PLAN OF CO	DRRECTION	
		•	TAC		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE
F 157	survey team on May	6, 2011 through review of taff interviews, and	F	157			
i r c c r c r c	facility; and verified the involved in the signification administration administration demonstration of liquid narcotics on lost Nursing on site at the signed without notice the individual and the individual and the individual and in May 4, 2011.	of medication administration administration administration May 6, 2011. The Director ne start of the survey had e on May 4, 2011 and an sing had been established					
to Ad Sh aff	ervices and a Register confirm accuracy of dministration Records neets to determine if confected. In addition the						
nurs right to be after Physical	ts of medication adm	of in-service logs that the ion regarding the five inistration; alert charting hift for seventy-two hours timely notification of the resing and the					

### DEPARTMENT OF HEALTH AND HI MAN SERVICES CENTERS FOR MEDICARE & MEL AID SERVICES STATEMENT OF DEFICIENCIES

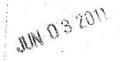
PRINTED: 05/17/2011 FORM APPROVED

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPLE C	CONSTRUCTION	OMB NO	. 0938-03
1	IDENTIFICATION NUMBER:	A. BUILDING	CHOCHON	(X3) DATE S COMPLE	URVEY
JAME OF PROVIDE	445476	B. WING			**************************************
NAME OF PROVIDER OR SUPPLIER		070==-		05/0	6/2011
HILLCREST HEALTHCARE SO	UTH	1758 H	DDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STAT	EMEA :	KNOX	VILLE, TN 37920		
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT		
	O IDENTIFYING INFORMATION)	PREFIX TAG (	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)		COMPLETION DATE
two nurses if the amo less than 5 milliliters. the facility's Audit For Notification to begin M conducted daily throug decreased to two time through July 19, 2011	pe of administration of liquid prification and signatures by unt to be administered is The survey team verified m for Medication Error lay 5, 2011 and be gh May 19, 2011 then	F 157			
4.) The survey team v daily monitoring by a R week duration, beginning May 19, 2011, then two months until July 18, 20 audit of Medication Erronotification of the Physic Director of Nursing; a 10 Medication Administration receiving liquid narcotic milliliters to ensure compare verifying the dose and signal Administration Record; a charting log against their to verify alert charting control The survey team verified Regional Director of Clinical Compliance review of 10 and related data weekly unmonitoring time. The survey facility's plan to relay resurvey team verified Regional Director of Clinical Compliance review of 10 and related data weekly unmonitoring time. The survey facility's plan to relay resurvey and recommendation of the review and recommendation of the province of the survey and recommendation of the plant of the	or Sheets for proper cian, Administrator, and 20 % audit of the 20 Records of residents doses less than 5 coliance of two nurses gning the Medication and auditing of the alert medication error reports empliance for 72 hours. The facility's plan for the cal Services to perform 20% of the audit forms antil the end of the 20 yey team verified the 20 less for the Quality				

If continuation sheet Page 7 of 43

TATEME	ENT OF DEFICIENCE					FOR	D: 05/17/2 M APPRO\
ND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	ULTIPLE (	CONSTRUCTION	OWR M	<u>0. 0938-0:</u>
	3	in the state of th	A. BU	LDING		(X3) DATE	SURVEY LETED
14145 -		445476	B. WIN	ıg		}	CCIED
	PROVIDER OR SUPPLIER					05	100100
HILLCF	REST HEALTHCARE S	OUTH		STREET	ADDRESS, CITY, STATE, ZIP CODE		06/2011
				1130 H	ILLIVOOD DRIVE		
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES		KNOX	VILLE, TN 37920		
TAG	REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		PROVIDER'S PLAN OF CORRE	CTION	(YE)
		- OKWATION)	TAG		CROSS-REFERENCED TO THE APP		COMPLETIC
F 157	Ca-#		+	.	DEFICIENCY)	HOLKINE	DATE
. 107	Indinaca Floir ha	ge 7					<b>-</b>
	plan. The average	risions are needed to the audit	F 15	07		8	
	to have the Outlife	am verified the facility's plan					
	Improvement comm	темпечения поставления					
- 1	Medical Director, an	d Dietary, Activities					
- 1	and Pharmance, Busine	ess office, Social Services,					
- 1	and Pharmacy depa	rtments.	K			8	
İ		198		1 .			
	Non-compliance con	tinues at a "D" level for			19	1	
1!	monitoring of correcti	ve actions. The facility is		1			
	required to submit a	plan of correction					
	c/o #27994					8	
		42		F165			
165 4	83.10(f)(1) RIGHT To	O VOICE GRIEVANCES	**	1. Res	sident #13 was interviewed on	May 19,	
יש ש=	VITHOUT REPRISAL	OLITE VAINCES	F 165	2011	Dy Social Services Director ro		
A	resident has a right		.,	concer	experience. Resident #13 express. Resident #13 family was	ressed no	
di	scrimination or repris	o voice grievances without	1	Uy SUC	Jai Services Director on May	contacted	
in	clude those with resp	ect to treatment which has		and ex	pressed no concerns.	19, 2011	
be	en furnished as well	as that which has not been				1	
Tui	nisnea.	ndo not been		2011 b	nt #26 was interviewed on Ma	ıy 19,	
	FI 18			ADL c	y Social Services Director reg are. This resident voiced no c	arding	
Thi	is REQUIREMENT i	s not met as evidenced	- 1	during	interview. Resident #26 famil	oncerns	
				membe	T Was contacted by Social Som	rices	
Ba	ised on medical reco	rd review, interview, and a		Directo	on May 19, 2011 and indicat	ted he	
the	facility foiled to	icern and Comment log,		nas no c	concerns.		
	(#13, and #26) of thi		1.				
	dents reviewed were		. ]		2 1 7		. [
1	,	vesugated.					
The	finalia.					1	1
ine	findings included:						
1	6.2			a .			u a
)EC7/00 0	9) Previous Versions Obsolet		3.0			. 1	

	ERS FOR MEDICAR NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		£	FOR	D: 05/17/2 M APPROV
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	OMB N	<u>0. 0938-0</u>
		I TOMBER.	A. BUILDI		(X3) DATE	SURVEY
	2000 SESSE TO SES	445.55	1	-	COMP	LETED
AME OF	PROVIDER OR SUPPLIER	445476	B. WING			
	EST HEALTHCARE S		ST	TREET ADDRESS, CITY, STATE, ZI	05/	06/2011
		ООТН	1 -	1758 HILLWOOD DRIVE	PCODE	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		KNOXVILLE, TN 37920		
PREFIX TAG	REGULATORY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID			
	- LOULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTOR) CROSS-REFERENCED TO		(X5)
			TAG	i civelaced 10	HE APPROPRIATE	(X5) COMPLETION
F 165	Continue		<del> </del>	DEFICIENC	(Y)	DATE
00	The second of the second	ge 8		2 411		
1	Resident #13 was n	5 - d - in -	F 165	2. All residents were interv	viewed by Social	1
- 1	March 25, 2011 with	diagnoses to include	1 1	Director on 5/17/	11 - 5/19/11	
- 1	Cerebral Vascular A	ccident, Vascular Dementia,	1 1	regarding any concerns.		
	Depression, and And	emia, vascular Dementia,	1 1			
1				3. Social Services Director	was inserviced on	
1	Medical record revious	w of the Minimum Data Set,	į į	of Tolki of Mullillistrator of	n Concern and	
10	dated April 8 2014 -	w of the Minimum Data Set, evealed the resident required		Comment Policy.	- Joneon and	
10	one person assist to	evealed the resident required				
.   8	assist with eating.	meal set-up and limited	1	Resident Council meeting v	was hold	
- 1	and that caulig.		su (	5/19/11 and the Administrat	vas neid on	*
F	Review of the same.			grievance and investigation	or reviewed the	
l i	Og dated Avenue 130	Concern and Comment		o and myestigation	process.	
re	og, dated August 18	, 2010, revealed the	1	All concerns and	12	
a	iven enquels "	a concern of not being	1	All concerns and comments	are reviewed by	
ft-	e facility of time to	a concern of not being eat. Continued review of		micraiscipilliary ream which	imal- I	
in	dicated)	eat. Continued review of and Comment Log (no date	- 1	Trummibuator, Director of X	Instruction of A	
d	revealed the	e Director of Nursing (DON)		- "Cotol Of Nulsing Minimi	Im Data Car	
l uc	ocumented in the inv	estigation section		Cool unidiol. Medical Record	do Carta	
10	Resident has adapt	ive utensil and oots	- 1	outvices, Activity Director I	Juman	
P	0%"	and eats	1000	NOSUMICES HIISTRACE OFF.	C - C	
176	eview of the Concern	and Comment Les	1 .	Tumissions Director Faciliti	00 1/	
iei	realed no documenta	and Comment Log	1 .	The Dividity I Wallaber Mondo	Tr theman I To the	
to	the resident or inves	ation the DON has spoken tigated the resident's	D 07	To account a comment invaction		1
gne	evance.	agated the resident's	0	conducted and an acceptable	roceluti-	
-		1	f	found.	resolution is	
Re	sident #26 was admi	tted to the facility	1			
Sep	otember 22, 2008 wi	the diagnoses including	4	1. Beginning 5/26/11 Social S	lamina.	
Cer	ebralvascular Accide	ent and Hypertension.	D	Director will interview 10 resi	CIVICES	1
1.		in and rypertension.	fa	amily per week for form	idents and/or	1
Med	lical record review of	the resident's nurse's	aı	amily per week for four week	s for concerns	
note	s, dated April 30 30	the resident's nurse's 11, revealed the resident	fa	nd comments, then 10 resider	nts and/or	. 1
was	alert and oriented an	in, revealed the resident	1 10	amily per month for two mon 00% compliant.	ths and/or until	
assis	stance for all Activitie	iu required total	.	to to compliant.		- 1
	MOUNTE TO TOT ALL ACTIVITIES	es of Daily Living.	A	Il audit no 1		- 1
Revi	ew of the "Concorn -		A C	all audit results will be report	ed by the	
revea	ew of the "Concern a	ind Comment" log	1 50	ocial ocivices Director to the	monthly.	
regar	aled a concern voice	a on July 6, 2010,	1 0	uality Assurance Performance	o Immuna	2.0
soile	" frequently member	er "finding (the resident)	1 1110	ocumes to review and recom	mandation	
reves	d" frequently on visits alled no investigation	continued review	. ,	is committee will determine	if any	1
	IVESTIGATION .	Completed	rev	visions are needed to the audi		10
Tevea	oouganon	completed regarding		reprous are needed to the single	t plan	10.00



STATEM	ENT OF DEFICIENCE					FOR	D: 05/17/
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. (X2) MU	JLTIPLE CO	NSTRUCTION	OMB M	O. 0938-0
		30.00.00.00.00.00.00.00.00.00.00.00.00.0	A. BUIL			(X3) DATE	SURVEY
NAME OF	F PROVIDER OR SUPPLIER	445476	B. WING	s			
						05	/06/2011
HILLCI	REST HEALTHCARE	SOUTH	- 1	1758 HII	DRESS, CITY, STATE, ZIP CODE LWOOD DRIVE		00/2011
(X4) ID	SUMMARY	ATEMEN	- 1	KNOXV	ILLE, TN 37920		
PREFIX	REGULATORY OF	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	ID	T			
		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO		(X5) COMPLET
					ROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
F 165	Continued From pa	age 0					
	whether the concor	rn was substantiated.	F 16	The Q	Quality Assurance Performance	9	
				mpro	vement Committee consists of	f	
	Interview with the A	administrator and Director of		Admi	distrator, Medical Director D	rector of	
	Nursing on May 3.	2011, at 9:00 a.m., in the		Hermit	ig, Assistant Director of Nurce	na.	1
30	conference room, c	onfirmed the voiced concerns		numa	Resources, Minimum Data	Cat	
	were not investigate	ed.		Direct	inator, Treatment Nurse, Adm	issions	
l				Manao	or, Business Office Manager,	Rehab	
i	c/o # 27457			Faciliti	er, Medical Records, Social S	ervices,	
1	GO# 2/45/			Manag	es Management Director, Die er, and Activity Director. Die	tary	18
				Pharma	acist reports are reviewed, and	ician and	
248	483.15(f)(1) ACTIVIT	FIFO		consult	ants attend as needed.	these	5/26/11
S=E	INTERESTS/NEEDS	IES MEET	F 248		as needed.	- 1	1111
			1 240	F248		1	
-	The facility must prov	ride for an ongoing program	}	1. Resid	dent #15 was interviewed on	5/6/11 by	
	of activities designed	to meet, in accordance with		and Acti	VILY DIrector regarding her d	noima da	
it	he comprehensive	to meet, in accordance with		use a bi	Utili to sween her room her:	mtama-t	
į ti	he physical, mental,	ssessment, the interests and and psychosocial well-being		III SCWII	IE Illaterials and reading mate	rials	
10	of each resident.	poychosocial well-being	1	I Clateu	O Sewing Resident #15		
.			1	THE AIG	wed by the Activity Director 4	0	
1	his REOLUDES			determin	ic current interests and the		
b	V:	is not met as evidenced	* 1	was und	ensive assessment and care p	lan	
B	Based on review of	47.74		these pre	ated by Activity Director to r	eflect	
m	edical record review,	ctivity participation logs,		pre	eferences on 5/6/11-5/24/11.		
int	terview, the facility for	observation, and		Residen	t #12 was interviewed by the		
ac	tivities, in accordance	e with the comprehensive		Activity	Director to determine current		
as	sessment, was offer	ed to two (#15 and #12) of	1 3	mierests,	and the comprehensive asses	cmont	
thi	rty-one residents revi	iewed; and the facility	1	and care	plan was undated by the Acti-	.:4	
fail	led to ensure attempt	ts were made to engage	1 -	DIFFCIOL	o reflect these preferences on	5/6/11	
res	sidents in two of two	group activities observed.		- 5/24/11	• !	270711	
		Julia observeu.		A atirit			1
The	e findings included:			Activity	director inserviced Activity		
1	aniaa mended:	2 (2007) 12 (2007) 12 (2007)		resident	on 5/18/11 regarding honoring	g	
Res	sident #15 was admit	tod to the same	1	engaging	references and involving and		
				onducted	the residents in the activity be	ing	- 1
Diab	betes and Emphysen	na Including			•		. 10
		te Event ID. 7779444	1	9 9			

	ERS FOR MEDICAL NT OF DEFICIENCIES					FOR	D: 05/17/ M APPRO
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CO	NSTRUCTION	OWR M	<u>⊃. 0938</u> ⊣
		, and the second	A. BUILD	DING		(X3) DATE	Survey Leted
		445476	B. WING	.  -		)	LETEU
NAME OF	PROVIDER OR SUPPLIER	110470	J. WING	-	:		
	EST HEALTHCARE S		s	TREET AD	DRESS, CITY, STATE, ZIP CODE	05/	06/2011
	THE THORKE	<b>БООТН</b>		1758 HIL	LWOOD DRIVE		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		KNOXVI	LLE, TN 37920		
TAG	REGULATORY OR	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING MEETING	_ID		PROVIDER'S PLAN OF CORD		
	WORT OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	6			COMPLE
				1	OSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
F 248	Continued From pa	700			oel loiel(Cf)		
- 1	- Tom pa	ige 10	F 248				
-	Review of activity of	out at	. 440	2. All	residents were interviewed b	ov the	
- 1	December 2010 an	articipation logs for November/		ACLIVI	ly Director or the Activity A	caintant	
- 1	resident attended a	- Sandary 2011 revealed the		1 5/0/11	- 3/24/11 for current interes	to and 41	
.	and December but	attended only two activities in		Compte	cilcustive assessments and on	wo mla	
1.	January.	two activities in		were u	pualed by the Activity Direct	tor to	
١,	Madia I			reflect	these preferences.		
1:	viedical record revie	w of a physician's progress		3 411 1	liaa		
1:	recident of February	W of a physician's progress 24, 2011, revealed the		Accieto	licensed nurses, Certified Nu	ırsing	
	esident stated "noth	24, 2011, revealed the ling to live for" and would		incervia	nts and Activity Assistant w	ere	
10	products on medica	ations if (the resident) had an	1	Directo	ced by Administrator and Acr on 5/6/11 – 5/20/11 to assistant	tivity	
s	ervices progress	ations if (the resident) had an all record review of social		resident	s to any activity the	st	
2	011, the resident	tes revealed on February 24,	1		s to any activity they wish to	o attend.	
fa	acility and returned o	res revealed on February 24, as admitted to a psychiatric		4. Begir	nning 5/26/11 Activity Direc		
1				addit II v	C PIOIII) activities non vical		
M	edical record review	of social services progress	1	"CORS, E	Hell IV grown activities non-		
no	otes, dated May 2, 2	011, revealed "(The		two mor	oths and/or until 100% comp	liant	
re	sident) talks about s	011, revealed "(The sewing and how (the	- 1				
100	sident) enjoys it."	o man lane		Beginnin	ng 5/26/11 Activity Director	will	
Inte	enview with 45		1	THICK ATCA	v tell residents a week for for		
5	2011 at 0.25	vity Assistant (AA) on May	1	weeks, u	ien 10 residents a month for	41	
rev	ealed the AA	at the Nurse's Station,		months a	nd/or until 100% compliant	to	
enic	oved sewing and b	riawai e trie resident		cusure cu	irrent interests are identified	.	
indi	vidual sewing rolete	ad not offered any		All andit		. 1	
duri	ing one-to-one activ	ad not offered any ed activity to the resident ity visits. Continued		Activity I	results will be reported by the	he	
inte	View with the AA	ity visits. Continued		Assurance	Director to the monthly Qual	lity	27
requ	lested a broom to s	weep in the resident had	l r	neetings	for review and recommenda	t	
roon	n, but the resident v	weep in the resident's vas not given a broom due	1	This com	mittee will determine if any	tions.	
to sa	afety concerns. Cor	ntinued interview with the	r	evisions a	are needed to the audit plan.	- 1	
AA r	evealed the residen	t was not offered a broom	1		pian.		
unde	r a controlled enviro	onment (to address safety		702		1	- 1
CONF	rmed the	onment (to address safety one activity visits and		20			
not h	onored.	activity visits and activity preferences were					. 1
1.00	onoreu.						
Resid	lent #12 was admitt	ed to the facility on April					- 1
	" 'E was admitt	ed to the facility on April	- 1	=	1		
		The same of the same	1				

TATEME	NT OF DEFICIENCE				;**	FOR	D: 05/17/20 M APPROVE
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)	MULTIPL	E CONSTRUCTION	OMB NO	D. 0938-039
		TO THOM NOWIBER:		JILDING	THE STATE OF THE S	(X3) DATE COMP	SURVEY
		445476	B. W			-	-C1CO
IAME OF	PROVIDER OR SUPPLIER	1 110470	J. VV				
HILLCR	EST HEALTHCARE S	ОПТН		STREE	T ADDRESS, CITY, STATE, ZIP	CODE U5/	06/2011
(X4) ID				1	HILLIAGOD DRIVE		
PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		LINE	OXVILLE, TN 37920		
TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF	ıx	PROVIDER'S PLAN OF C	ORRECTION	(X5)
		- CAMPATION)	TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	E APPROPRIATE	COMPLETION
F 248	Continue				DEFICIENCY	)	DATE
. 240	The state of the s	ge 11	1	т	ha Oualita A		
1	23, 2010 with diagn		F2	48	he Quality Assurance Perf	ormance	
1	Renai Disease and	oses including End Stage Cerebralvascular Accident.	1	A	nprovement Committee co	nsists of	
- 1	Medical reserv	and Accident.		N	dministrator, Medical Director oursing, Assistant Director	ctor, Director of	
l	Minimum Deta Carre	w of the April 30, 2010,		Н	uman Resources, Minimur	of Nursing,	
1	had limitation of man	W of the April 30, 2010, MDS), revealed the resident		C	oordinator, Treatment Nurs	e Admissions	
1.1	voluntary movement	official and partial loss of		L D	dector, Business Office M.	mager Dobok	
1	feet on both sides	or arms, nands, legs, and		141	allager, Medical Records	Social Commisse	
13	30, 2010 MDS 1010	ortanded review of the April		1.0	Cillues Management Direc	tor Dietom	
16	palance could not be	led the resident's sitting tested without physical help.		IVI	anager, and Activity Direct	or Distinion and	
		tooled without physical help.		1 11	armacist reports are review	ved, and these	~/ /
"	Medical record review	of the April 30, 2010 MDS,		CO	nsultants attend as needed.	20	5/26/11
d	id not have	of the April 30, 2010 MDS, ms" revealed the resident		1			
a	ctivity.	ns" revealed the resident nce for exercise as an					
1	-uvity.					a,	
0	bservation on May 2	2044		1			- 1
re	vealed the resident in	2011, at 10:45 a.m.,				E 8800 E1	
a	reclined geri chair	n the dining room asleep in Continued observation		1		•	*
/ re	vealed a video plant	onarided observation		1		1	1
ex	plaining the physical	g on the television movements for Tai Chi (a	88		40	**	
me	ethod of exercise, bre	movements for Tai Chi (a eathing, and relaxation).		1	6 5	10	- 1
Inte	anziowasiu z	or and relaxation).			2 2		
201	11 at 4:15	ty Director on May 4,				8	- 1
con	11, at 4:15 p.m., in the	e conference room.	j			- 1	- 1
cap	ability to participate	not have the physical					
con	prehensive assessm	in rai Chi, and the	.		_ a		
exe	rcise as a need or in	terest for the resident.			- I		- 1
			- 1			1	- 10
Obs	ervation on May 2, 2	011 at 10:00 a m	,				
			1			**	
the C	group activity "Curren	it News". Continued	1			1	- 1
			- 1				
the r	eauing articles, from	the local newspaper, to	- 1	79		es e	
Manr	nequine" Committee	n article on "Forensic	- 1				
							1 .
1	- John Lany read fro	om the newspaper, with					
	40						

	ERS FOR MEDICAF INT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIED (X1)					PRINTED: FORM A	(PPRO)
	- COMMENTAL TOP	IDENTIFICATION NUMBER:			ONSTRUCTION	(2)	OMB NO. (	1938-0.
				UILDING			COMPLET	ED
ME OF	PROVIDER OR SUPPLIER	445476	B. V	VING				
				STREET A	DDRESS, CITY, STATE		05/06/	2011
	EST HEALTHCARE S	ЮИТН		1758 HI	LLWOOD DRIVE	, ZIP CODE		000 000 000 000 000 000 000 000 000 00
X4) ID REFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		KNOX	ILLE, TN 37920			
TAG	REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI		PROVIDER'S PLAN	OF CORRECTION	v T	
			TAC		(EACH CORRECTIVE ROSS-REFERENCED DEFICE	TO THE APPROPE		(X5) OMPLETI DATE
248	Da	ge 12				<del></del> -		
	no attempts made t	o image!	F	248				
1	residents in the acti	vity.						
	Interview with the A	ctivity Director on May 4,			88			
1	2011, at 4:20 p.m., i	n the conference room,						
- 1	confirmed the AA fa	n the conference room, iled to attempt to engage						
	residents in the "Cur	rent News" activity; the	1					
t	the A.D. to lead the !	usly stated a preference for						
1 (	as observed) the ac	this activity; and		1				
a	activity for the reside	nts.		1				
	50							
c	Observation on Mour							
re	evealed the dining ro	3, 2011, at 10:45 a.m., om completely full with	55.76					
re	esidents, while a vide	om completely full with so was playing on the		1	X.			
le m	elevision demonstrati	ng Tai Chi upper body					120	
ob	Servation revealed	Continued						
en	gaged and actually	completing the movements						
de	scribed on the video	with fourteen residents			(6)			
		ep or with eyes closed.			12 121			
Inte	erview with the Active	ih. D:			10		- 1	Year
201	11, at 4:25 p.m., in the	Director on May 4,		1	110			
				1	Sec. 7.			
TOO	m.	is brought to the dining		1				. 1
	255T-3		4	Q) 	198			
1.	*** *** ***			472	0 2 8			- 1
C/O #	# 27457		İ		8 ,			
l	(i) (i) (ii) (ii)	9 2 4 4			2 600		1	- 1
483.	20(k)(3)(i) SEDVIOR	C DDOV #T				e e T		- 1
PRO	FESSIONAL STAN	S PROVIDED MEET	F 281	F281	1 m			
				1. Resid	ent #20 is no longe	r at the facility	on	
must	services provided or	arranged by the facility		2/24/11.		7		- 1
must	meet professional s	tandards of quality.					-	
	) Previous Versions Obsolete				1 10		1	- 1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & ME PRINTED: 05/17/201 AID SERVICES STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445476 NAME OF PROVIDER OR SUPPLIER 05/06/2011 HILLCREST HEALTHCARE SOUTH STREET ADDRESS, CITY, STATE, ZIP CODE 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 281 Continued From page 13 F 281 Resident #2 was transferred to the This REQUIREMENT is not met as evidenced Emergency Room on 9/5/10 and returned on 914/10. Based on facility policy review, review of a Narcotic Count Sheet, medical record review, The physician was notified of medication review of facility documents, review of Standard error on 2/24/11 by the Director of Nursing. of Practice for Advanced Trauma Life Support Administrator educated Director of Nursing and interview, the facility failed to take appropriate action when 1) significant narcotic on 3/4/11 on the Policies and Procedures for medication errors for one resident (#20) occurred narcotic counts, notification of change, and and 2) a fall resulting in a fracture with an the incident event management procedure. inappropriate transfer occurred for one resident (#2) of thirty-one residents reviewed. An investigation was begun on 3/4/11 by the Director of Nursing. The facility's failure to investigate significant narcotic medication errors and to immediately The Pharmacy Consultant was notified of the notify the Administrator, physician, and medication error on 3/2/11, and was involved pharmacist was likely to cause serious injury, in the investigation of narcotic count error. harm, impairment or death to resident #20. LPN #2 is no longer employed as of 3/19/11. On May 4, 2011 at 12:05 p.m. in the office of the Administrator, the Administrator and the LPN #1 was unaware of the medication error Corporate Nurse Consultant were informed of the until 5/4/11. She was counseled and Immediate Jeopardy. educated on 5/6/11 with return demonstration of administration of liquid narcotics by The findings included: Director of Nursing. Resident #20 was admitted to the facility with LPN #3 was inserviced on 9/10/10 by the diagnoses including Diabetes Type II, reoccurring Director of Nursing regarding appropriate Congestive Heart Failure, Chronic Obstructive assessment of residents after falls. Pulmonary Disease/Oxygen-Dependent, Morbid Director of Nursing is no longer employed as of 5/4/11 and an interim Director of Review of the physician's orders for February Nursing was established on 5/4/11 and was 2011 revealed on February 19, 2011, an order for inserviced on the Event Management Policy. Roxanol (a liquid morphine preparation) 1-2 mg (milligrams) PO (by mouth) q 1 (every one) hour CMS-2567(02-99) Previous Versions Obsolete Event ID: ZTPW11

	ERS FOR MEDICAR ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			FOR	D: 05/17/2 M APPROV
· · • ·	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CONSTRUCTION	(X3) DATE	O. 0938-0:
	*:		A BUILI	DING	COMP	SURVEY LETED
IAME OF	PROVIDER OR SUPPLIER	445476	B. WING	3	1	10.2 3.100 <del>-3.3</del> 10.1
			<del></del>		05/	06/2011
AILLEC!	REST HEALTHCARE S	ОИТН	,	TREET ADDRESS, CITY, STATE 1758 HILLWOOD DRIVE	, ZIP CODE	0/2011
(X4) ID	SUMMARY			KNOXVILLE, TN 37920		
PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING THE	(D			
	MEGOLATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED A		(X5)
			TAG	I CIVILIOED I	U THE APPRODUATE	COMPLETE DATE
F 281	Confinued From			DEFICIE	NCY)	
	Continued From pag	ge 14	F 281			
	PRN (as needed).		1 201		. 1:	
	Record review of the	41.		2. An audit of 100% of the medication sheets was do	e liquid narcotic	
I	dated February 20 2	third Narcotic Count Sheet		of Nursing on 3/4/11. No	other residents	
İ	amount of parcetic	(used to record the	4	identified as being affecte	d residents were	
- 1	for resident #20 rouse	mailling) for liquid morphine				
- 1	adhered to the ton	a sucker-type label		All liquid narcotics record	Is were reviewed by	
- 1	following information i	nt of the sheet with the included: "(resident #20's		the Regional Director of (	Clinical Services	
- 1!	name); room#; MORF	PHINE SULFATE 100 MG/5	1	and a Registered Nurse of	15/4/11 No other	
1:	VIL (milliliters) substitu	Ited for ROXANOL 20	1.	residents were found to be	affected.	
18	MG/ML SOLUTION; 0	2/19/11(date): Take	1			
10	0.05ML-0.1ML (1-2MG	EVERY HOUR AS	: J	All incidents with falls wi	ll be audited for	2
f	om the phant	ity) 30 ML (total dispensed		proper assessment techniq	ue after a fall by	*1
1."	om the pharmacy)."	(15 mi disperised		Director of Nursing or Ass	sistant Director of	
C	Ontinued musicus is a	to the second se		Nursing for two weeks, th	en three times a	
re	Vealed six I DNs to	Dose Given' column	. [	week for three months and compliant.	/or 100%	- 8
N:	arcotic Count Chart	recorded on the third		compilant.		
20	11. at 2.00 nm	Suming February 20		Beginning 5/25/11 Resider	at Frank D	* .
l'an	en as 0.1 ml Davi	an ridu recorded the dose		involving falls will be aud	ted daily by the	
1.LP	Ns had subtracted		. 1	Director of Nursing, Assist	ant Director of	
the	'Quantity Remaining	Column and #		Nursing or nursing supervi	sor for two wooles	
Sul	sequent two LPNs (ti	column and the he nightshift/LPN #2 and		then three times a week for	three months	
the	dayshift/LPN #1) had	he nightshift/LPN #2 and subtracted 1.0 ml from		and/or 100% compliance to	assure falls	. 4
line	total liquid remaining	when administering the	. 1	protocol for proper assessn	nent technique is	- 1
33	id MSO4 narcotic from	when administering the n 1:00 a.m., on February		followed.		:
201	2011, through 11:00 :	n 1:00 a.m., on February a.m., on February 22,		2 * .		. 1
nm (	1, the entries were as	a.m., on February 22, follows: "2-21-11 9	** .	3. Inservice was given to al	l licensed nursing	- 1
rem	0.1 mL (dose given) 2	8.3 mL (quantity		Stall by Director of Nursing	on 3/4/11 - 1	
28 2	ml (quantity)	m 0.1 mL (dose given)		3/10/11 regarding measuring	g narcotic liquids	
mL o	dose given) 28.1 mL	m 0.1 mL (dose given) ng)2-21-11 11 pm 0.1	**	with return demonstration r	equired.	
rema	ining) 2-22-11 4	(quantity				
27.1	ining)2-22-11 1 am	U.1 mL (dose given)			1	. 1
mL (c	lose given) 26 1 ml	9)2-22-11 3 am 0.1	1			
remai	ning) 2-22-11 F	quantity			ľ	
					1	
mL (d	ose given) 24.1 mL (d	9/4-22-71 7 am 0.1	1		12.5	
	/ (	fucility	· · · I			

CALEM	ERS FOR MEDICAFENT OF DEFICIENCIES N OF CORRECTION	(X1) PRUVIDER/SUPPLIED/OLA	Iva:	Nu rie: - :		FOR	D: 05/17/2 M APPROV O. 0938-0
		IDENTIFICATION NUMBER:		MULTIPLE CONST	RUCTION	(X3) DATE	SURVEY
	*	1	A. BU	ILDING		COMP	LETED
AME OF	PROVIDER OR SUPPLIER	445476	B. Wil	NG		1	
				STREET ADDRE	00.000	05/	06/2011
	REST HEALTHCARE S	ООТН	- 1	1758 HILLWO	SS, CITY, STATE, ZIP CODE		Sec. of the sec.
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES		KNOXVILLE	TN 37920		
PREFIX TAG	REGULATION OF	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	D				<u>.</u>
	TORT OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFD TAG		COVIDER'S PLAN OF CORRECT H CORRECTIVE ACTION SHO		(X5) COMPLETIO
			1 1/10	CROSS	THE APPE	COPRIATE	DATE
F 281	Continued From page		1	1.	DEFICIENCY)		
	remaining) 2 00	ge 15	F 28	24		St. (Section 1)	
	23.1 ml (quantit	11 am 0.1 mL (dose given)	1 20	Facility po	olicy on Administering Co	ntrolled	
î	23.1 mL (quantity re	maining)"	l	Medication	is was revised by Adminis	official	· ·
- 1			1	and Directe	or of Nursing on 5/4/11 to	su ator	
- 1	Count Sheet for resi	view of the third Narcotic		that two nu	rses verify and sign off or	n the	
- 1	Count Sheet for residuscrepancy in the	dent #20 revealed a		Medication	Administration Record a	Il liquid	
- 1	February 22 2014	nount 'left to count' on		I narcotic do	ses less than 5ml On 5/6	/11 this	
- 1	Sheet revealed I	view of the Narcotic Count		revision wa	s added to the narcotic m	ed page	late.
- 13	administered a doco	(LPN#1)		poncy and	Med Pass Observation she	eet hy	
- 12	2011 at 11:00 a m	Theorem 1 repruary 22.	702	ine Regiona	Il Director of Clinical Ser	wicos	
- (	Column 'Quantity Dan	nd recorded 23.1 ml in the		and signed	by the Administrator and	Director	
1 1	evealed a line mode	Continued review		of Nursing.	- and und	Director	
1	emaining and 20 ml	a dirough the 23.1 total				1	
[	Director of Nurses (DC	and signed by the		All licensed	nurses were educated by	, 1	
1		,		Regional D	rector of Clinical Service		
Ir	iterview in the confer	2000		Director of	Nursing and Admissions 1	Nurse	
0	n May 3, 2011 at 10:	ence room, with the DON,		011 3/4/11 -	5/20/11 on the following	- 1	18
St	ated the mombine "	a.m., revealed the DON		requirement	s: verification of any liqu	id	
l m	atch the amount of o	and left in the bottle did not	- 1	narcotic less	than 5 mls by a second n	urse	
IRE	emaining on the Name	Quantity		who must al	so initial Medication		
the	3:00 p.m. shift chan	ge count on February 22,		Administrati	on Record Inservices al	so I	
20	11.	ge could on February 22,		included the	Five Rights of Medication	m I	
1.				Administrati	on, alert charting to be in	itiated	- 1
Co	ntinued interview revening shift LPN #7 etc	ealed the ones		on every sni	I for seventy-two hours a	fter a	
eve	ening shift LPN #7 sta	ted the amount	1	medication e	rror, timely notification of	ftha	
rem	naining was not accur	ate if the total amount		Filysician, D	rector of Nursing and the	. 1	- 1
give	en from the time the L., the evening of Feb.	PN had left at 11:00		Administrato	r after a medication error	. 1	
p.m	the evening of Febrer was 0.1 ml with a	uary 21 2011 to the		The Marie III			
pres	sent was 0.1 ml with e	ach subsequent 6		The Medical	Director and Pharmacy	1.	
dose	es. Continued interviences	W revealed the DON		Consultant w	ill be advised by the	i	40 t
ala r	no further questioning	about the amount		Administrato	r or the Director of Nursin	ng of	1
rema	aining to be 20 ml (eq	ual to 40 milligrams of		any medication	on administration error an	d will	
naro	otic medication), and	recorded 20 ml	. 1	be included in	the investigation process		
				Impression the Q	uality Assurance Perform	ance	
			i. 1	Improvement	process.		
in an	in to the left of 'Quan	tity Remaining', wrote		Director		1	
22 20	ml, and took no furth 111. During interview	er action until February		Director of N	ursing inserviced licensed	I	
40. 11	11. During intention	the DOM:		nuises on 9/1/	10 on proper assessment falls.	of I	1.0

IAIEMEN	RS FOR MEDICAR	(X1) PROVIDER/SUPPLIER/CLIA				OMB NO	APPROV 0. 0938-03
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE	SURVEY
			A. BUILD	-		COMPL	ETED
NAME OF	PROVIDER OR SUPPLIER	445476	B. WING				
			S	TREET AD	DRESS, CITY, STATE, ZIP COI	05/	06/2011
- ILLUK	EST HEALTHCARE S	ЮОТН	1	1/58 HIL	LWOOD DRIVE	DE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		KNOXVI	LLE, TN 37920		
PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CR	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OSS-REFERENCED TO THE A	CHOINDO	(X5) COMPLETION
E 204	1 (Aug. 1720)				DEFICIENCY)		DATE
F 281	Continued From pa	ige 16	F 004				
i	the morning of Feb	FUODI 00	F 281		ensed nurses were inserv	•	
İ	revealed the service	s questioned by the DON and		5/17/1	1 – 520/11 by Regional I	iced on	
				Clinic	al Services and Director of	f Nurcing on	
i	1:00 a.m., 3:00 a.m.	and 5:00 at		proper	assessment of residents	after falls.	
	on February 22, 201	1. During interview, the DON					
13	stated he/she did no	of realize the two doses given		4. Dai	ly monitoring by a Regist	ered Nurse	
	by LPN #1 on Febru	ary 22, 2011, at 7:00 a.m.,		for two	weeks, beginning May	5, 2011	
1	and 11:00 a.m., had	also been 1 ml each (20 mg		for the	h May 19, 2011, then two	times a week	
	nstead of 2 mg orde	ered) until "later."		until 1	ee months until August 18 00% compliant, to include	3, 2011 and/or	
F	Review of the facility	's policy 'Medication Error	13	audit o	f Medication Error Sheets	for proper	
1	.Reporting' revealed	d, "Procedures: a. In the		nounce	ation of Physician Admir	istrator and	
е	vent of a significant	medication error	į	Directo	or or Nursing: a 100% and	lit of the	
				Medica	ation Administration Reco	rds of	
a	tending physician	safety and welfare. b. The		residen	ts receiving liquid narcot	ic doses less	
la	avsician's orders	safety and welfare. b. The notified promptlyc. The		man 5	milliliters to ensure comp	liance of two	
re	sident is monitored	e implemented, and the		Medica	verifying the dose and sig tion Administration Reco	ning the	
di	rected."	closely for 24 to 72 hours as		auditing	g of the alert charting log	rd; and	
1_		1		medica	tion error reports to verify	alert	
Re	view of the 'Control	led Medication Storage'		charting	g compliance for 72 hours		
dis	icy and procedures	revealed, "e. Any		The Re	gional Director of Clinics	1 Services	
COL	ints is reported to the	ed substance medication		will per	Torm a compliance review	of 100% of	
imi	nediately The direct	te director of nursing		me audi	t forms and related data v	veekly until	
				uic chu	of the monitoring time.		
							=
disc	ne administrator. If a	a major	1971				*
uisc	LEDGIICA UCCINE 1	ha di !			# # # # # # # # # # # # # # # # # # #		- 1
	fies the administrator macist immediately	IF and concellent					
Inter	view with the DOM	at 8:45 a.m., on May 4,		F -		- +:	
	in the conforce	at 0.45 a.m., on May 4,	*	#		1975 B.	
			2.50	200			
had	not followed the faci			38%			

IMICMI	ERS FOR MEDICAR	(X1) PROVIDER/SUPPLIER/CLIA				FOR	D: 05/17/20 M APPROV
NO PLO	N OF CORRECTION	IDENTIFICATION NUMBER:	(X2) N	MULTIPLE CO	ONSTRUCTION	CINB N	O. 0938-03
		1	A. BU	ILDING		(X3) DATE	LETED
AME OF		445476	B. WI	NG		1	
	PROVIDER OR SUPPLIER					05	/06/2011
IILLCF	REST HEALTHCARE S	OUTH		STREET AL	DRESS, CITY, STATE, ZIP CO	ODE	00/2011
			- 1	1130 UII	-LWOOD DRIVE	3	
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	-	KNOXV	ILLE, TN 37920		
TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	×	PROVIDER'S PLAN OF CO	RRECTION	T
		THIS INFORMATION)	TAG		(EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
C 004	A NEW YORK THE TAXABLE TO A NEW YORK THE TAX			- 1	DEFICIENCY)	APPROPRIATE	DATE
F 281	Torrainada Fiorn na	ge 17				-	
	1 10110Wed tacility not:		F 28	81			
	medication error occ	cy when the significant curred; had not investigated					
	the 7.5 ml (equaling	150 mg) of morphine not		Alla	Ildit recults will be		
	accounted for on Fe	bruary 22, 2011; and had not		Direc	udit results will be report tor of Nursing to the mo	ed by the	1
ı	notify the administra	tor, physician, and consultant		Assu	rance Performance Impro	nthly Quality	1
j	pharmacist "immedia	ately."	1	meeti	ings for review and recon	vement	
- 1			l	This	committee will determine	if and it is	1
1	30, 2008 with at	mitted to the facility on April		revisi	ons are needed to the aud	it nlon	
.	Obstructive Description	oses including Chronic	iv S	The (	Quality Assurance Perform	na pian.	
	Hemorrhage.	oses including Chronic by Disease and Intracranial		Impro	ement Committee cons	iete of	
	maye,			Admi	nistrator, Medical Director	or Director &	
- 11	Medical record rovious			1 Muisi	ug, Assistant Director of	Murgina	150
- 11	Medical record review Minimum Data Set (N	of the July 15, 2010,		riuma	n Kesources, Minimum I	Data Sat	
į į	nad a history of falls in	IDS), revealed the resident the past 30 days and 180		Coord	mator, Treatment Nurse	Adminaiana	
10	lavs. Medical rooms	die past 30 days and 180		DIICCI	or, Business Office Mana	ager Dehoh	
p	Progress notes detail	review of physical therapy		Iviana	er, Medical Records So.	cial Compiess	
.   n	esident was safe to to	15, 2010, revealed the		raciiii	les Management Director	r Dietomi	
W	as referred to the res	storative program	-	ivialiag	er, and Activity Director	Disting	22
1.	12.21.	reduce program.	520	I Hai III	acist reports are reviewed	d and the	-1-1
IN	ledical record review	of nurse's notes, dated		consul	tants attend as needed.		5/26/11
10	eptember 5, 2010, review athroom) floor with a	vealed "Sitting in RP					- 1
10	athroom) floor with pa	ants down states, 'I lost my	- 1				
m	nance-c/o (complains	ants down states, I lost my s of) pain R (right) hip-can		\$11			
(10	wer extremiti	es) except for R (right) LE	1	9 4			
-re	sident verification	es) except for R (right) LE ed to w/c (wheelchair)	9				
(ar	sident vomited x (tim	es) 1 lg (large) amt	- 1	S 0 _			
in (	inch) shorter than I	es) 1 lg (large) amt ce red, shaking, R leg 1/2				•	
me	inch) shorter than L (	left)" Continued		1/+			- 1
the	resident was subsection	f nurse's notes revealed					
em	ergency room with the	uently transferred to the e diagnosis of right hip					- 1
	ture.	e diagnosis of right hip		7.0			1
-			.				. 1
Rev	iew of facility docume	ents revealed a nursing	.		100 100 100 100 100 100 100 100 100 100		1
						, fa	
shou	ıld not be moved unti	I: ROM (range of	1				
567/02-9	9) Previous Versions Obsolete			70			S 1

## DEPARTMENT OF HEALTH AND FUNDAM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA				OMB NO	0. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG	<u> </u>	(X3) DATE : COMPL	SURVEY
NAME OF THE	445476	B. WING_				
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTHCARE SO	DUTH	1 7	REET ADDRESS, CITY, S	É	05/0	06/2011
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFEREN	PLAN OF CORRECT TIME ACTION SHOU CED TO THE APPRO EFICIENCY)	I D DE	(XS) COMPLETION DATE
ROM, c/o (complain) evidence of fx (fracturesident comfortable pillow/blankets and needs (emergency meeds) Continued review of from September 9, 2010 "corrective action" becresident after the resident after the resident after the Directive with the Directive w	pain/injury; neur s if head injuryshould c completed (complete) of pain/injury or display re)-Do Not Movemake where they are with otify M.D. (physician) and dical services), as needed." acility documents revealed D, LPN #3 received a cause the LPN moved the dent exhibited cossible fracture. ctor of Nursing on May 3, the conference room, ved the resident from a on (into the wheelchair), I the resident's inability to extremity, and the resident's on shorter than the left".	F 281		EFICIENCY		
Standard of practice for Support requires "the advanced trauma life suby the American College the standard of care for built around a standardize evaluation. This protocol immediate life-threatening identified and addressed potential. The objectives of the trauma patient are	development of the apport (ATLS) approach of Surgeons. ATLS is frauma patients, and it is zed protocol for patient lensures that the most of conditions are actively in the order of their risk of the initial evaluation.					

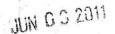
TATEME	NT OF PERIODICARI			190	175			PRINT FC	TED: 05/17/2
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE	CONSTRUCT	TON		(X3) DA	NO. 0938-0 TE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	445476		/ING					
HILLCR	EST HEALTHCARE SO		-	1 .750	HILLWOOD	DRIVE	TE, ZIP CODE		5/06/2011
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX		ER'S PL RRECTIVERENCE	AN OF CORRIVE ACTION SID TO THE APICIENCY)		(X5) COMPLET DATE
- 1	Continued From pag stabilize the trauma life-threatening injuri supportive therapy, a rapidly organize eithe transfer to a facility therapy"	patient, (2) to identify es and to initiate adequate and (3) to efficiently and	F:	281			,		
ir c te in M	vas removed on May Allegation of Complian mmediacy of the jeop orrective actions were earn through reviews	ardy was effective from rough May 6, 2011, and 6, 2011. An acceptable arce, which removed the ardy, was received and e validated by the survey of facility documents, staff ations conducted onsite on yey team verified the se by:							
faction faction for the faction of the faction of the faction faction for the faction	Verifying one nurse edication error was nurse edication error was nursely and verified the volved in the signification counseled and edication administration of iquid narcotics on Manursing on site at the greed without notice of	e involved in the significant o longer employed by the other remaining nurse							
Serv to co		d Nurse on May 4, 2011 Medication				8 x			

I CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 20 of 43



A I EME	ERS FOR MEDICARI									FORM	D: 05/17 VI APPRO
D PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE	CONST	RUCTIO	N		- Iox	MB NO	0. 0938- SURVEY
			A. BUI	LDING					(***	COMPL	ETED
ME OF	DDO) (ID C)	445476	B. WIN	IG					1		
	PROVIDER OR SUPPLIER							_	$\bot$	05/0	06/2011
LLCR	EST HEALTHCARE SO	ОТН		1758	HILLW	SS, CITY DOD DR	, STATE,	ZIP COD	E		
(4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		KNO	XVILLE	, TN 3	7920	3.4			
REFIX TAG	REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		1000	II CURR	ECTIVE A	CTION S		220210	(X5) COMPLET
281	Continued		-				DEFICIE	VCY)			57.112
	Continued From pagaffected. In addition observation of liquid May 6, 2011.	the surveyors conducted narcotic administration on	F 28	31							
- 1		3									
th Roco de thr cookse	nursing staff and revienurses received information and the initiated on every after a medication error of the initiated on every after a medication error of the initiated on every after a medication after a medication after a motification of revision ddressing the change arcotics requiring very onurses if the amounts of the initiation to begin Manual to the initiation to begin Manual the initiation to the initiation of two times or initiations and the initiation of the initia	of the medication policy of administration of liquid ification and signatures by to be administered is the survey team verified for Medication Error by 5, 2011 and be a May 19, 2011 then weekly for two months Compliance to be nal Director of Clinical									
wee May mor aud notif Dire Med rece	ek duration, beginning 19, 2011, then two to the thick until July 18, 201 it of Medication Error fication of the Physicist ctor of Nursing 2, 200	Sheets for proper an, Administrator, and Manual Man									

STATEME	NT OF DEFICIENCIES					FOR	D: 05/17/2 M APPRO\
AND PLAN	N OF CORRECTION	(X1) PRCJER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		DISTRUCTION	(X3) DATE	O. 0938-0: SURVEY LETED
NAME OF	PPOVEDE	445476	B. WING	s		-	
	PROVIDER OR SUPPLIER					05/	06/2011
HILLCR	REST HEALTHCARE S	нтио	ľ	17 JO HIL	DRESS, CITY, STATE, ZIP LWOOD DRIVE	CODE	
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES		KNOXV	ILLE, TN 37920		
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT ROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE	COMPLETE DATE
F 281	The state of the s	ge 21					-
	ventying the dose of	nd at a to the	F 28	1			1
ļ	Charting less	ord; and auditing of the alert					
į	to verify alart about	the medication error reports		1			
1	The survey team us	g compliance for 72 hours.			- F		
	Regional Director of	Climination of the line in the		1	112		
.	a compliance review	of 100% of the audit forms	15	1			
	and related data wee	ekly until the end of the		1			
- 1	facility's plan to me.	e survey team verified the		1		1	0.0
12	Assurance Performa	results to the Quality		iii		1	
r	nonthly through the	ice improvement committee		ă		1	
f	or review and recom	mandati monitoring time	i				
te	eam verified the facil	ity's plan to have the Quality					
A	ssurance Performan	ice Improvement committee	1				
- l'ul	lan. The sum revisi	ons are needed to the audit	1		8		
to	have the Quality A	ons are needed to the audit n verified the facility's plan					
In	provement committee	odiance Performance	- 1				
			- 1	350			
Me	edical Director, and I	Dietary, Activities	1.	88 74			
				2	0		
all	d Pharmacy departm	ients.			12 K 15		
1 .			1			17,	M 25 929
No	n-compliance continu	les of a Man					
				99			
requ	uired to submit a pla	of correction		ta 10			8
			1				
	# 27457 #27994	a.	1				- 1
1 30 1	r£1 334						
4 483.	25(c) TREATMENT	SVCS TO	4.				- 1
PRE	VENT/HEAL PRESS	SURE SORES	F 314	F314			. 1
	100 July 100			1. Treatn	ent Nurse assessed Re	esident #8's	
resid	on the comprehen	sive assessment of a ensure that a resident		heels, per	rformed treatment and	floated the	
1 icalde	on, the facility must	ensure that a resident		heels and	no adverse outcomes	identified an	

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 22 of 43

INIEME	ERS FOR MEDICAR ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIED/CLIA	(X2) I	MULTIPLE CONSTRUCTION	FOR	D: 05/17/2 M APPROV O. 0938-03
		IDENTIFICATION NUMBER:		ILDING	(X3) DATE	SURVEY
					COMP	LETED
ME OF	PROVIDER OR SUPPLIER	445476	B. WI	NG		
				STREET ADDRESS, CITY, STATE, Z	05/	06/2011
	REST HEALTHCARE S	ООТН		1758 HILLWOOD DRIVE	IP CODE	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		KNOXVILLE, TN 37920		
REFIX	REGULATORY OF	MUST BE PRECEDED BY FULL	_ ID	PROVIDER'S PLAN OF	CORRECTION	
		O IDENTIFYING INFORMATION)	PREFI		TION SHOULD BE	COMPLETIC DATE
314	Continued From page	70.00		,		
	who enters the facility	10 22 h	F 3	14 Resident #8 wound was eva	luated by	
	does not develop pro	ty without pressure sores		physician and new orders n	oted on 5/6/11	1
i	individual's clinical	ssure sores unless the		Resident #8 Pressure Sore I	Risk Assessment	
İ	they were unavoidab	le; and a resident having	1	and Pressure Ulcer checklis	t were completed	i B
- 1	pressure sores recei	ves necessary treatment and		and care plan updated on 5/ Treatment Nurse.	18/11 by	
	provent as	ves necessary treatment and nealing, prevent infection and		readificit tyurse.		
- 1	prevent new sores fro	om developing.		Resident #23 was assessed a	and treatment	
1	2	* 9		performed by the Treatment	Nurse on 5/4/11	
17	This REQUIREMENT	is not met as evidenced		and no adverse outcomes id	entified.	Til .
b	by:	is not met as evidenced	828	Faces were La	4	
1.1	Based on medical rec	cord review soviews		Resident #23 wound was ev	aluated by the	
W	yound tracking report	s, facility policy review,		physician and new orders no	oted on 5/6/11.	
0	oservation, and inter	riew the facility failed to		Resident #23 Pressure Sore	Risk Assessment	
re	esidents (#0 lucer	riew the facility failed to		and Pressure Ulcer checklist and care plan updated on 5/1	were completed	
re	viewed. The facility's	failure to consistently		Treatment Nurse.		( <b>*</b> )
of	pressure sores regul	prevent the development		Treatment Nurse was inservi	ced on 5/6/11 on	
an	d #23, who develope	d pressure		proper staging and wound tre	eatments by	
		d pressure sores.		Regional Director of Clinica	Services.	
In	e findings included:		1	2 45 000	4	. 19
Ro	cidont 40	4	1	2. An assessment was comple	eted by	
witt	diagnosos is al	ed on February 19, 2010,		physician on 5/6/11 on all reshouse acquired pressure ulcer	sidents with in-	. 1
Mal	diagnoses including	Failure to Thrive,	- 1	orders were written as approp	rs and new	- 1
	chosis and Anxiety.	rallure to Thrive, zheimer's Dementia with	. 1	as approp	mate.	
1 :				A team consisting of Treatme	nt Nurse.	- 1
Med	lical record review of	the Quarterly Minimum		Regional Director of Clinical	Services and	- 1
Data	Set (MDS) dated No	ovember 16, 2010, and		Treatment Nurse Consultant	performed	
revo	Annual MDS dated Fo	bruary 16, 2011		wound assessments on all res	idents with	
				current wounds, both in house admitted with, on 5/11/11 and	e acquired and	
				wound treatments and updated	d wound	.
revea	led the Annual Mos	sessments. Review		treatments per physician order	r.	. 1
	Unionside design	ordied the resident		i ∓n persit Til I der sammen Til Til Til	1	1.
mobili	ity,	one bersou tot ped				1.
					11.	: 1:
7(02-99)			: 11		H	

ALEME!	ERS FOR MEDICAR  NT OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	l (Ya) M	I V TIDI D		FOR	D: 05/17/20 M APPROV D. 0938-03
		IDENTIFICATION NUMBER:	A. BUII		NSTRUCTION	(X3) DATE COMP	SURVEY
ME OF	PROVIDER OR SUPPLIER	445476	B. WIN	G			
				070		05/	06/2011
	EST HEALTHCARE S	OUTH		1130 HILL	RESS, CITY, STATE, ZIP CO	DE	
X4) ID REFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		KNOXVII	LLE, TN 37920		
TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF COF EACH CORRECTIVE ACTION OSS-REFERENCED TO THE		(X5) COMPLETIC DATE
314	Continued From pa	ne 22	1		DEFICIENCY)		
	Medical record reviews	014 a E 41 a m	F 31	4		•	538
İ	Predicting Pressure	Sore Risk' assessed the		Assista	ant Director of Nursing a	and Treatment	
1	resident on Februar	y 24, 2011 with a score of 13, ate risk' for processes		Murse	completed head to toe sk	cin	
].	indicating a 'modera development.	y 24, 2011 with a score of 13, ite risk' for pressure sore		assessi	ments on all residents on	5/18/11.	
				Pressur	e Sore Risk Assessment	s and Pressure	
	Record review of the	resident's care plan dated		Olcer I	revention Checklists as	indicated	
	December 3, 2010, i	ncluded the problems, "Self		were co	ompleted on $5/18/11 - 5/18$	25/11 on all	
6	extensive assista	y to Dementia, needs		residen	is and care plans undated	d by Assistant	
b	extensive assistance	and "Risk for skin		Directo	r of Nursing and Treatme	ent Nurse.	1A.2
(1	bladder and howell	d to) inc' (incontinent) B/B		3. Licer	nsed nurses and Certified	()	14
.   ir	tegrity by payt rouse	.Goal - Maintain intact skin		Assista	nts were inserviced by Ti	i ivuise	nulle
l C	are plan revealed he	Review of the		Nurse o	n 5/5/11 - 5/24/11 on as	reatment	corets
Α	pril 11, 2011, "Bliste	erL (left) heelwill show	10	resident	s' heels are floated per c	are plan and	100,0015
S/	s (signs and sympto	oms) of healing, will not		ucaune	ul illierventions Nursing	staff on any	sheets
tre	low s/s of infection beatment as	bms) of healing, will not by 5/20/11wound care		type of	leave will be inserviced a	prior to	it in the
1		loat neels."		perform	ing patient care upon ret	urn.	teru
Re	cord review of the r	progress note from the	1		30 00	11	Sheets with nterventi
CO	nsulting psychiatric	nurse practitioner on March		Supervis	ning 5/26/11 Treatment		
9,	2011, revealed, "l	ong h/o (history of	1	four wee	sor will audit 20 residents ks then 20 residents per	s a week for	
ae	pression, delusions,	agitationNo increase in	1	three mo	onths and/or 100% compl	month for	
inci	navior symptomsL	agitationNo increase in ying in bed todayWill try	1	accuracy	of weekly skin assessme	lance for	
me	rease in Remeron (a	an anti-depressant		moating i	neels as indicated by care	nlan and	1
stim	Julant) " Poview of	s a hypnotic and appetite		ueaumeni	interventions and comp	letion by	- 1
fron	the consulting pour	the next progress note	- 1	licensed i	nurse.		
on A	April 13, 2011 reven	diautic nurse practitioner		D' '			- 1
and	lethargic. Always in	hed is his simulation		Numer	g 5/26/11 Assistant Direc	ctor of	
toda	y. "	. Journal lying in bed		ramsing.c	or Director of Nursing wi	ill andit all	
	y <b>1</b> <u>2011                                  </u>	*	.	and/or 10	wounds weekly for three 0% compliance to assure	months	
for A	ical record review of	the physician's orders		staging an	d treatment.	proper	
					1		1
		otic) to 0.5 mg dtime) for 7 days and					
then	discontinue.	durie) for / days and		*8			- 1
							*
16	) Previous Versions Obsolete	- Jrs. 6	1		[NO 55 SEE]		- 1

	ERS FOR MEDICAR  NT OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIED OF			FOR	D: 05/17/20 M APPROV D. 0938-03
		IDENTIFICATION NUMBER:	A. BUII	ULTIPLE CONSTRUCTION DING	(X3) DATE COMP	SURVEY
AME OF	DD01-F	445476	B. WIN			FFIFD
	PROVIDER OR SUPPLIER				05/	06/2011
HLLCR	EST HEALTHCARE S	OUTH	1	STREET ADDRESS, CITY, STAT 1758 HILLWOOD DRIVE	E, ZIP CODE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		KNOXVILLE, TN 37920		
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLA	N OF CORRECTION ACTION SHOULD BE	(X5) COMPLETIO
	No contract of the contract of			THE CITETIOED	TO THE APPROPRIATE	DATE
F 314	- ontinded From pa		F 31	4		
	Observations at 6:3	0 a.m., and 1:00 p.m., on N		Pressure Sore Risk Ass	sessment and Pressure	
-	2, 2011, revealed th	o a.m., and 1:00 p.m., on Notes in the mottes.	flay	Older Prevention Chec	klist if indicated will	
İ	at 8:50 a	on the mattress. Observation 3 2011	on	quarterly assessments	admission assessments,	
	resident lying in head	7 3, 2011, revealed the	511	assessments for accura-	and significant change	
1	nursing assistant (C)	being fed by a certified	1	Assistant Direct	or of Muraina an	
1	on the mattress.	being fed by a certified NA) with the left foot resting	ı	Director of Nursing for	One month than 20	
- 1	ed to the top of the desired to the top the top		1	assessificiles per month	for two months - 11	
1	nterview in the confe	erence room, with Licensed		100% compliance is att	ained.	
F	Practical Nurse (LPN	#4) on May 5, 2011, at 4:0			1	
15	.m., verified the fac	#4) on May 5, 2011, at 4:0 ility used pillows for floating	00	All audit results will be	reported by the	
1 6	ne residents' heels o	ff of the bed and this was	l [,	Director of Nursing to t	he monthly Onalis	
1 "	requently ineffective including resident #9	due to the residents		TADOULATICE PELICITINANCE	mprogramant	
fr	om under #8	due to the residents ) kicking the pillows out		mocuillys for review and	TOOOM J.	
1"	om under their feet	and legs.	1 1	This committee will defi	ermine if ann	
				revisions are needed to t	he audit ala	
In	ledical record review tegrity Assessment	of the 'Weekly Skin	1. 1	THE Quality Assirance I	Parforman	
20	11 through April 20	the week of March 23		Improvement Committee	e consists of	
inc	Cluding April 6 2044	", revealed each week	:1 1	Administrator, Medical I	Director, Director of	
re:	sident #8's skin integ	the assessment stated	1 1	Nursing, Assistant Direct	tor of Nursing,	
	- integ	inty was intact.	1	Human Resources, MDS Admissions Director, Bu	, Treatment Nurse,	
Inte	erview on May 3, 20	11, at 3:30 p.m., at the	1 1	Manager, Rehab Manage	siness Office	F - 12
nui	sing station, with LP	N #6 (responsible for the	1 .1	Social Services, Facilities	I, Menal Records,	0
Apı	ril 6, 2011, skin asse	N #6 (responsible for the ssment) revealed, "hard	1 1	Director, Dietary Manage	o Management	
toa	assessdoesn't wan	ssment) revealed, "hard t to be botheredI missed	1 1	Dietician and Ph	larmacist romants	
It (n	eferring to the left he	el blister)"	1 1	reviewed, and these const	Ilfante attend on	,
				needed.	5/	26/11
Trac	cking Report	E" PRESSURE Wound			.1	, ,
resid	cking Report reveale	a on April 6, 2011,				
				10 Table 10		- 1
2.1.	Progress-New " Po	e (cm/centimeters)-0.7 x	. 1	20 20		
Trac	king Report dated A	view of the Wound		•		- 1
						- 1
size	in cms "0.6 x 0.4 with	th 0 depth "		. 1		1
		o depui.	-	9		
	K.		- 1			- 1

INICIAL	ERS FOR MEDICAR NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIED/OLL	(X3) 14	II TIDI E CO			-	FOR	D: 05/17/2 RM APPRO\ O. 0938-0:
		IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CO DING	NSTRUCT	ION		(X3) DATE	SURVEY
AME OF	PROVIDER OR SUPPLIER	445476	B. WING	3				1	
			<del></del>	OTDEEN				05	/06/2011
	EST HEALTHCARE S	ЮТН	ľ	1130 HIL	TWOOD I	TY, STATE, DRIVE	ZIP CODE	*3	
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES		KNOXVI	LLE, TN	37920		*	
TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	100		ER'S PLAN RRECTIVE A ERENCED T DEFICIE	OTHE APP	A	(X5) COMPLETION DATE
F 314		ge 25					•		+
	Medical record review	DIV OF HE - DI	F 31	4	-63		¥0		
1	Notes of April 15, 20	of the Dietary Progress  11, revealed the first entry by							
j	left heel process	ian (RD), nine days after the		1					
	"April wt (weight) 1	lear the identified, as follows:		İ					
	(approximately) 165	1754 (pounds). Usual wt ~							1
	52% (percent) avera	ge per 7 day reviewwhole							
	TID Needs on addition	ige per / day reviewwhole a day)house supplement							
11	protein/day Increase	ional 15 gm (grams)	50	1					
İ	nealing "	ed nutrition needs to promote						8	
s p	tated, "(resident) was ressure ulcer develo		8	5)			# # # # # # #	****	
ca ob me the res	pare Nurse, revealed observed as the same easured on April 27, which was down the sident was down the side	2011. During observation,			£		***		
faci incli Defi	uding Vascular Dom	10, with diagnoses entia, Encephalopathy,							
Med	lical record review of	the Minimum Data Set arch 18, 2011, revealed			8 0				,
	esident had impaired		100						

	THERS FOR MEDICAL	TH AND HUMAN SERVICES  RE & MET ID SERVICES				100		PRINTEI FORM	D: 05/17/2011 M APPROVED
AND	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)	MULTIPLI UILDING	E CONSTRUC	CTION		(X3) DATE: COMPL	0. 0938-0391 SURVEY
NAME	E OF PROVIDER OR SUPPLIEF	445476	B. W	ING			-		
HILI	LCREST HEALTHCARE	отн		1/58	HILLWOO		ODE	<u> </u>	06/2011
PRE	I) ID SUMMARY ST EFIX (EACH DEFICIENC AG REGULATORY OR	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	100011	IN 37920  ADER'S PLAN OF CORRECTIVE ACTION  FERENCED TO THE DEFICIENCY	N SHOU E APPRO		(X5) COMPLETION DATE
FS	Continued From pactivities of daily livulcers.	age 26 ring, and had no pressure	FS	314		•			,
	December 10, 2010 risk of developing p Score for Skin Risk indicates higher risk 14 = Moderate Risk Assessment Part 2. Ulcer Risk Assessm scores for Part 1 and Risk Assessment. If below or the score for complete the Pressu List and implement of prevention" Contin Sore Assessment reversered by the prevention of the score of th	the Pressure Sore Risk the resident had severe had at least three or more for pressure ulcer lisease, Anemia, and of the Care Plan dated	o er						
	Medical record review on notes for March and Appresident was receiving s	of the physician progress ril, 2011, revealed the steroid therapy (side	-				a a		

Event ID: ZTPW11

CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 27 of 43

Facility ID: TN4706

	ERS FOR MEDICAR			•	s	*	FOR	D: 05/17/2 M APPRO\
D PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE	CONSTRUCTION	1	OWB N	<u>O. 0938-0;</u>
			A. BUII	LDING			(X3) DATE	SURVEY LETED
ME OF	DDO: 45	445476	B. WIN	IG			1	
	PROVIDER OR SUPPLIER						05	/06/2011
ILLCR	EST HEALTHCARE S	ОИТН		1758 I	ADDRESS, CITY HILLWOOD DR	, STATE, ZIP COD	E	
X4) ID	SUMMARY STA	Trans		KNO)	CVILLE, TN 3	7920		
REFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INTERIOR	ID					
,		OUT DESCRIPTING INFORMATION)	PREFIX TAG		しつしい しいれん	'S PLAN OF CORF ECTIVE ACTION S ENCED TO THE AI DEFICIENCY)		(X5) COMPLETIC DATE
314	I DON I DON	ge 27				•		
	effects include elever	ofod blassis	F 31	4				
- 1	poor wound healing	), had been experiencing poor					9	
- 1	blood glucose contro	), nad been experiencing poor of with very high levels, and		1	-			
- 1	control the Dist	djusting insulin dosages to						
j			1					
	Medical record review	w of the Wound Tracking		1				
	Report revealed the	resident was noted to have a				÷		
bli	blister to the left heel	on April 12, 2011, noted as						
a stage 2 pressur		cer, and treatment was						
"	a stage 2 pressure ulcer, and treatment implemented. Continued review of the National Tracking Report revealed April 20, 2011 wound was a stage 2 pressure.							
u	Yound was a sta	aled April 20, 2011, the						
100	Centimeters) by 2.2	pressure ulcer, 2.3 cm		,		((*)		
a	nd improving Conti	ni, described as a blister,		1			1	
T	racking Report rove	rided review of the Wound					1	
W	ound was a stage 2	pressure ulcer, 1.8 cm by	•	1			- 1	
3.	.4 cm, described as	pressure ulcer, 1.8 cm by a blister, and improving.						
М	edical record	, and improving.					1	
re	vealed the following	of the Departmental Notes					- 1	
4:4	40 AM. Change of S	April 12, 2011,						
tx	(treatment) orders	Left heel with new			5		1	
floa	atedApril 13, 2011,	1:23 PM Typus		(*)	**		1	
COI	ntinues care for left hes, heels floated in	ieel, shoes left off all						
um	es, heels floated in b	DedApril 27, 2011, 12:38				*	1	
Wo	reatment continu	les to L (left) heel ulcer.					1	
(are	ea of dead ties	lately 20% black eschar				20 E	1	
bed	granulating and also	ith the remaining wound				100		
sma	all amount of vellouse	all. No odor is noted and	- 1			* 3	1	1
rem	oved bandage +2 =	or urainage noted on				· · · · · ·		- 1
					8			. 1
P.00	CHETANII COUNTING TO	float heels while in					1	
bed.					70	8 0	0	
Inter	View with the T		8		, , , , , , , , , , , , , , , , , , ,			
200	view with the Treatm	nent Nurse and el on May 4, 2011, from	= 20		E se		1.	
ODSA	~ HOLL OF THE PATENT	OLOD Blov. 4 CO44 4	77			100 SM	1	- 1
obse		el on May 4, 2011, from	1					998 350

STATEME	ERS FOR MEDICAR				72		FOR	D: 05/17/2 M APPRO
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION		(X3) DATE	<u>0. 0938-0</u>
		445476	B. WING				) COM	LETED
NAME OF	PROVIDER OR SUPPLIER	145478	B. VVIIV	<u> </u>				
	EST HEALTHCARE S			STREET 1758 H	ADDRESS, CITY, STATE, ZI	P CODE	105/	06/2011
(X4) ID	SUMMARY		1	KNO	XVILLE, TN 37920			
PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING THE	ID	$\top$			10	
TAG		OS ISENTIFFING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOU		(X5) COMPLET DATE
i	1:50 p.m., until 2:05 revealed the wound blood-filled blister, n with an area of each	p.m., in the resident's room, first appeared as a neasured 3.4 cm by 3.6 cm har approximately 2 cm by 2.5	F 31	4				
y d (I P	revealed, "To stage be able to see the bar ou cannot stage pre covered with necrotic lebrided and the bas NPUAP [National Pro- canel], 2007). Until do coument that the ulc	e of the wound is visible essure Ulcer Advisory lebridement can be done, er is unstageable"				٨		
5: restop pre obs blis app res res con pillo	sident was in bed with or of one folded pillow essing into the mattre servation and intervister appeared, the reproved diabetic shoet ident's closet and notident. Continued ob a firmed the treatment was and utilized three to or or or or or or or or or or or or or	ent's room, confirmed the the the lower legs placed on v, and both heels were ess. Continued ew confirmed, when the esident had been wearing es, which were now in the longer worn by the servation and interview the policy of the servation and interview th						
Med Trea 5:00 and confi	dical record review a atment Nurse on Ma p.m., and 5:20 p.m. at 5:10 p.m., in the r irmed the nurse had	nattress.  Ind interview with the y 4, 2011, at 4:50 p.m., at the nursing station, resident's room, not documented when	<u> </u>					
2567/02-0	9) Previous Versions Obsolet	e Event ID: ZTPW11				ł.		1-

INIEME	ERS FOR MEDICARI NT OF DEFICIENCIES OF CORRECTION	H AND HUMAN SERVICES  E & MED D SERVICES  (X1) PROVIDER/SUPPLIER/CLIA				FOR	D: 05/17/2 M APPRO\
ALD I DAM	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE	O. 0938-0:
		Chica State and Control of State (Control of Sta	A. BUII	DING	0.4000	COMP	LETED LETED
IAME OF		445476	B. WIN	G			
	PROVIDER OR SUPPLIER					05/	06/0044
HILLCR	EST HEALTHCARE SO	MITU		STREET ADI	DRESS, CITY, STATE, ZIP C	ODF	06/2011
				1130 HILI	WOOD DRIVE	.E.E.E.	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		KNOXVI	LLE, TN 37920		
TAG	REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		PROVIDER'S PLAN OF CO	PRRECTION	T
		OLIVII TING INFORMATION)	TAG		EACH CORRECTIVE ACTION OSS-REFERENCED TO THE		COMPLETI
					DEFICIENCY)	APPROPRIATE	DATE
F 314	Continued From pag	ne 29					-
- 1	the blister had "hurse	in	F 31	4			
	review and interview	confirmed the wound had		1			
-	inaccurately been de	escribed as a blister on the		1			
	the wound tracking Rep	oort April 20 and 27, 2011;				-	
	2. when escher	urately described as a Stage					
	Prevention Checklist	present; the Pressure Ulcer					
	December 10, 2010	that not been completed on		Ŕ			
i i	dentified as a high ric	when the resident was					
	pressure ulcers; and t	the resident's heels had not				1	
b	peen floated off the m	ne resident's heels had not lattress as required by the				1	
0	are plan and treatme	nt interventions		1	2	1	
- 1		antervendons.			83	1	
333 4	00.05/				#11	. 1	
	83.25(m)(2) RESIDE	NTS FREE OF	F 000				
3-3 3	IGNIFICANT MED E	RRORS	F 333	8			
TI	he facility must one			0			
ar	ny significant medicat	e that residents are free of		F333	)*i		
- 1	o madin medical	ion errors.	- 1	1. Resi	dent #20 is no longer at	the facility on	
	IGN TODAY SANAN		-	2/24/11		and and and	
Th	is REQUIREMENT i	s not met as evidenced	1	TI.	196	1	
by:		met as evidenced	- 1	i ne pny	ysician was notified of	nedication	
No	ased on facility policy rcotic Count Sheet in	review, review of a	1	error or	2/24/11 by the Directo	r of Nursing.	
obs	rcotic Count Sheet, n	nedical record review	5 <sub>80</sub>	Admini	strator advantad D:		
ens	ture one recident (tree	ew, the facility failed to		on 3/4/1	strator educated Director I on the Policies and Property	or of Nursing	
med	dication errors of third	b) was free of significant		narcotic	counts, notification of	change and	
revi	dication errors of thirt	y-one residents		the incid	lent event management	procedure	
were	e free of significant n	ailure to ensure residents nedication errors was	- 1		100	1	
		ury, harm, impairment,		An inve	stigation was begun by	the Director	
or de	eath to resident #20.	, nam, impairment,	6:	of Nursi	ng on 3/4/11.		- 1
i		* *		The Di			
Adm	viay 4, 2011 at 12:05	p.m., in the office of the		medicati	macy Consultant was n	otified of the	
Com	inistrator, the Admini	strator and the	2 4	in the in	on error on 3/2/11, and vestigation of narcotic of	was involved	)
- C. P	ediate Jeopardy.	strator and the ant were informed of the		m are m	congation of harcotic c	ount error.	. ]
	ato occipatory.				. 4.	1	
	<u> </u>		]				- 1
	) Previous Versions Obsolete				4		

CX1   PROVIDER SUPPLIER   A45476   A BUILDING   C3D ATTE SURVEY COMPLETED	DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES		10		PRINTE	D: 05/17/201
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NAME OF PROVIDER OR SUPPLIER  HILLCREST HEALTHCARE SOUTH  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECISEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 333  Continued From page 30 The findings included:  Resident #20 was admitted to the facility with diagnoses including Diabetes Type II, reoccurring Pulmonary Disease/Oxygen-Dependent, Morbid Obesity, Chronic Anemia related to slow Gastro-Intestinal Bleeding requiring intermittent blood transfusions, Dementia with Depression, and Liver Failure with Blood Disorder diagnosed in December 2010.  Review of the nurse's progress notes for February 19, 2011, a 10:15 a.m., revealed, "Spoke with (names of two sons). Total comfort care agreed. No hospitalization. New order for MSOA (morphine, a narcotic) and Adropine (decreases secretions)Will monitor."  Review of the physician's orders for February 2011 revealed on February 19, 2011, an order for Roxanol (a liquid morphine preparation) 1-2 mg (milligrams) PO (by mouth) q 1 (every one) hour PRN (as needed).		IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE	SURVEY
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and Director of Number of Manager	PRN (as peoded)	1) q 1 (every one) hour		Facility	policy on Administering Co	ntrolled	
Record reviews on 5/4/11 to require,			. 1	and Dire	tons was revised by Admini	strator	
that two nurses world, and a true of the third at a second of the two nurses world, and a true of the two nurses world.	Record review of the third	Narcotio Campa	* .	that two	nurses verify and sign off	require,	
Medication Administration Description	dated February 20, 2011 (	used to record the		Medicat	ion Administration Record a	ll liquid	
amount of narcotic remaining) for liquid morphine  amount of narcotic remaining) for liquid morphine  for resident #20 revealed a still with a still revision was added to the narcotic management and the still revision was added to the narcotic management.	amount of narcotic remain	ing) for liquid mombine		narcotic	doses less than 5ml. On 5/6	5/11 this	1
for resident #20 revealed a sticker-type label  adhered to the top right of the	adhered to #20 revealed a	sticker-type label		revision	was added to the narcotic m	ed pass	4 8
				policy ar	nd Med Pass Observation she	eet by	
name): room# (number): MODEL WATER 120's	name): room# (number): M	ed: "(resident #20's	. 1	and sign	onal Director of Clinical Ser	vices	
100 MG/5 ML (milliliters) substituted of Nursing	100 MG/5 ML (milliliters) ou	ORPHINE SULFATE		of Nursir	ng.	Director	
PAY WIVE ZU MIGRAL COLLITION.	TO WILL SO WILLIAM COM	LITION . I.			ь.	1	. 1
VZ 13/11(Udie): 18ko n ochi o ahii (a anni	Value (uate): Take n new	I A 41 m (4					
ML (total dispensed from the pharmacy)."	wir (total dispensed from the	>pharmacy)."	[			1	
-2567(02-99) Previous Versions Obsolete Event ID: ZTPW11 Facility ID: TM/706	-2567(02-99) Previous Versions Ob.			1			. 1

	DEPA	RTMENT OF HEALTH	AND HI "AN SERVICES				PRINTE	D: 05/17/2011
Ts	STATEME	NT OF DESIGNATION	& MEDID SERVICES			*	· FOR	MAPPROVED
1	ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A	MULTIPLE CO	NSTRUCTION	OWB.M	O. 0938-0391
		( <b>x</b> .)			ILDING		(X3) DATE	SURVEY PLETED
L			445476	B. WI				22.20
ľ	VAME OF	PROVIDER OR SUPPLIER	1.0000				ÓE	(00/004)
	HILLCR	EST HEALTHCARE SO		-	STREET AD	DRESS, CITY, STATE, ZIP CODE		06/2011
_		- INOAKE SO	ОТН		1758 HIL	LWOOD DRIVE		1
	(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES		KNOXVI	LLE, TN 37920		1
	TAG	REGULATORY OR LSO	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFD	x / ,	PROVIDER'S PLAN OF CORRE	CTION	T
_			O IDENTIFYING INFORMATION)	TAG		EACH CORRECTIVE ACTION SH OSS-REFERENCED TO THE APP		COMPLETION
	F 200					DEFICIENCY)		DATE
	F 333	Continued From page	9 31		All lic	ensed nurses were educated	by	$\vdash$
	į	Continued review of t	ha ID	F 33	33 Region	nal Director of Clinical Ser	/ices,	
	l				on 5/4	or of Nursing and Admission 11 – 5/20/11 on the follow	ns Nurse	1 - 1
	- 1				require	ements: verification of any	ianid	
		given as 0.1 ml Povi	id all had recorded the dose	∍	narcoti	ic less than 5 mls by a secon	id nurse	1
		LPNs had subtracted	an amount of 0.1 ml from		who m	ust also initial Medication		
	- 13	the 'Quantity Remainir	ng' column and the		include	istration Record. Inservice	s also	4
					Admin	ed the Five Rights of Medic istration, alert charting to b	ation	- 1
	įt	he total liquid remaining	au subtracted 1.0 ml from		on ever	ry shift for seventy-two hou	rs after a	<b>1</b>
	li	quid MSO4 parcette for	ig when administering the	1	medica	tion error, timely notification	on of the	
	2	2, 2011, through 11:00	om 1:00 a.m., on February 0 a.m., on February 22,		Physici	an, Director of Nursing and	I the	
	2	011; the entries were	as follows: "2-21-11 9	l .	Admin	istrator after a medication e	rror.	- 1
	re	m 0.1 mL (dose given)	28.3 mL (quantity		The Me	edical Director and Pharma		ľ
	2	3.2 mL (quantity rome)	pm 0.1 mL (dose given)	1	Consult	tant will be advised by the		2 19
	m	L (dose given) 29 1 m	1119)2-21-11 11 pm 0.1		Admini	istrator or the Director of N	ursing of	10
•00					any me	dication administration erro	r and will	1 *
	mi	(dose given) 20	m 0.1 mL (dose given) ning)2-22-11 3 am 0.1		through	ided in the investigation pro the Quality Assurance Per	cess	1
•	rer	maining) 2-22-14 F	- (quartuty		Improve	ement process.	ormance	1 .
	25.	1 mL (quantity remain	m 0.1 mL (dose given) ning)2-22-11 7 am 0.1				1	
	mL	(dose given) 24.1 mL	(quantity		4. Daily	monitoring by a Registered	l Nurse	: 1
្	7.0		m n a i / ·	1	through	weeks, beginning May 5, 2	011	1.
	120.	1 mL (quantity remain	ing)"		for three	May 19, 2011, then two tin	ies a week	Ι'.
4	Con	tinued record review (	of the third at	. ' -	until 10(	ocompliant, to include a	100%	
. 3					audit of	Medication Error Sheets for	rproper	
					notificat	ion of Physician, Administr	ator and	. [
•					Medicati	of Nursing; a 100% audit of Nursing; a 100% audit of the condition Administration Records	f the	
2	adm	inistered a dose of Mic	ractical Nurse (LPN#1)		residents	receiving liquid narcotic d	OSes less	
	2011	at 11:00 a m. and ro	out on February 22,	.	man 5 m	illiliters to ensure complian	ce of two	
					nurses ve	eritying the dose and signing	o the	. 1
No.				• • • • • • • • • • • • • • • • • • • •	Medicati	on Administration Record:	and .	1
	1	ining and 20 ml writter tor of Nurses (DON).	n and signed by the		medication	of the alert charting log aga on error reports to verify ale	inst the	
	1	or or rigines (DON).			charting	compliance for 72 hours.	en l'a	
	1		200 La 18 18 18 18 18 18 18 18 18 18 18 18 18		9		1	A 10. 10

IS-2567(02-99) Previous Versions Obsolete

Event ID; ZTPW11

Facility ID: TN4706

If continuation sheet Page 32 of 43

JUN 03 2011

#### DEPARTMENT OF HEALTH AND HI " "AN SERVICES CENTERS FOR MEDICARE & MED. PRINTED: 05/17/2011 **ID SERVICES** FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445476 B. WING NAME OF PROVIDER OR SUPPLIER 05/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE HILLCREST HEALTHCARE SOUTH 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 333 Continued From page 31 Continued review of the 'Dose Given' column F 333 Facility policy on Administering Controlled revealed six LPNs had recorded on the third Narcotic Count Sheet beginning February 20, Medications was revised by Administrator and Director of Nursing on 5/4/11 to require 2011, at 2:00 p.m., and all had recorded the dose given as 0.1 ml. Review revealed the first four that two nurses verify and sign off on the LPNs had subtracted an amount of 0.1 ml from Medication Administration Record all liquid the 'Quantity Remaining' column and the narcotic doses less than 5ml. On 5/6/11 this subsequent two LPNs (the nightshift/LPN #2 and revision was added to the narcotic med pass the dayshift/LPN #1) had subtracted 1.0 ml from policy and Med Pass Observation sheet by the total liquid remaining when administering the the Regional Director of Clinical Services liquid MSO4 narcotic from 1:00 a.m., on February and signed by the Administrator and Director 22, 2011, through 11:00 a.m., on February 22, of Nursing. 2011; the entries were as follows: "...2-21-11 9 pm 0.1 mL (dose given) 28.3 mL (quantity All licensed nurses were educated by remaining)...2-21-11 10 pm 0.1 mL (dose given) Regional Director of Clinical Services, 28.2 mL (quantity remaining)...2-21-11 11 pm 0.1 Director of Nursing and Admissions Nurse mL (dose given) 28.1 mL (quantity on 5/4/11 - 5/20/11 on the following remaining)...2-22-11 1 am 0.1 mL (dose given) requirements: verification of any liquid 27.1 mL (quantity remaining)...2-22-11 3 am 0.1 narcotic less than 5 mls by a second nurse mL (dose given) 26.1 mL (quantity who must also initial Medication remaining)...2-22-11 5 am 0.1 mL (dose given) Administration Record. Inservices also 25.1 mL (quantity remaining)...2-22-11 7 am 0.1 included the Five Rights of Medication mL (dose given) 24.1 mL (quantity Administration, alert charting to be initiated remaining)...2-22-11 11 am 0.1 mL (dose given) on every shift for seventy-two hours after a 23.1 mL (quantity remaining)..." medication error, timely notification of the Physician, Director of Nursing and the Continued record review of the third Narcotic Administrator after a medication error. Count Sheet for resident #20 revealed a discrepancy in the amount 'left to count' on

MS-2567(02-99) Previous Versions Obsolete

Director of Nurses (DON).

February 22, 2011. Review of the Narcotic Count Sheet revealed Licensed Practical Nurse (LPN#1) administered a dose of MSO4 on February 22, 2011 at 11:00 a.m., and recorded 23.1 ml in the column 'Quantity Remaining.' Continued review revealed a line marked through the 23.1 total remaining and 20 ml written and signed by the

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 32 of 43

DEP/	ARTMENT OF HEALT	H AND F IAN SERVICES				DDILET	<b></b> > 10000000
STATEM	ENT OF DEFICIENCE	E & MED. JAID SERVICES		19		FOR	ED: 05/17/201
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I	MULTIPLE C	ONSTRUCTION	OMB N	O. 0938-0391
1	-	TOTTON NOMBER:		ILDING	CHSTROCTION	(X3) DATE	SURVEY
		445476	- 1			COMP	PLETED
NAME OF	PROVIDER OR SUPPLIER	1 445476	B. WI	NG		1	
	REST HEALTHCARE SO		Mariak.	STREET A	DDRESS, CITY, STATE, ZIP CODE	05/	/06/2011
		ОТН	10	1758 HII	LLWOOD DRIVE	<b>F</b>	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		KNOXV	ILLE, TN 37920		
PREFIX TAG	REGULATORY OF LE	MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORP.		*
		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	(19) (19)			(X5) COMPLETION
					ROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
F 333	Continued From pag	20 20	1	- I			l
20.00	Interview in the and	le 32	F 3	The Re	gional Director of Clinical S	ervices	
	on May 3 2011 at 4	erence room, with the DON,	1	will per	form a compliance review of	f 100% of	1 1
	stated the morphine	is a line, revealed the DON	ļ.			kly until	2
1	match the amount of	and left in the bottle did not		the end	of the monitoring time.	13	1 1
- 1	Remaining on the Ma	-0.1 m Quantity		All and	it recults will be	.	
- 1	the 3:00 p.m. shift cha	ange count on February 22,		Directo	it results will be reported by r of Nursing to the monthly	the	1
1	2011.	migo count on February 22,		Assurar	ice Performance Improveme	Quality	
1.	Confinued to 1			meeting	s for review and recommend	lations	
18	Continued interview re	evealed the oncoming		I his coi	mmittee will determine if an	v	
	evening shift LPN #7 s emaining was not ass	stated the amount		revision	s are needed to the audit pla	'n.	
19	liven from the time the	urate if the total amount		i		- 1	
l p	.m., the evening of F	nad left at 11:00	0	The Qu	ality Assurance Performance	•  ·	
i p	resent was 0.1 ml	bluary 21, 2011 to the		Improve	ement Committee consists of		
d	Oses, Interview recent	subsequent five		Nursing	strator, Medical Director, Dir	rector of	
) qu	uestioning about the a	ed the DON did no further mount remaining, judged		Human	Assistant Director of Nursi	ng,	
u	e amount remaining to	mount remaining, judged o be 20 ml (equal to 40		Coordin	Resources, Minimum Data S ator, Treatment Nurse, Admi	et	1.
20	my remaining marcotic m	o be 20 ml (equal to 40 ledication), and recorded		Director	Business Office Manager, I	SSIONS	
ha	d signed the M	ew confirmed the DON		ivianagei	, Medical Records, Social S.	ervices !	_#
col	d signed the Narcotic	Count Sheet in the		racinties	S Management Director Die	tam:	- 1
in 2	20 ml. and took no 6	arruty Remaining', wrote	. 1	Manager	, and Activity Director, Diet	ician and	- 1
123.	2011 During inter	dici acuon unul February	.	rnarmac	ist reports are reviewed and	these	. 1
the	Morning of Foh	w, the DON stated on		consultar	nts attend as needed.	15,	26/11
nun	se, LPN #2, was ques	23, 2011, the night shift stioned by the DON and	:			1/	- ///
reve	ealed the resident had	been given a 1 ml dose				1	1
1.00	iorphine (20 mg instea	been given a 1 ml dose ad of 2 mg ordered) at				1	. 1
on F	a.m., 3:00 a.m., and ebruary 22: 2011 Di	5:00 a.m., by LPN #2					
state	the/she did not	5:00 a.m., by LPN #2 Iring interview, the DON					
by LI	PN #1 on February 20	Iring interview, the DON ze the two doses given	- 1				
11:00	a.m. had also been	2011 at 7:00 a.m. and					. 1
instea	ad of 2 mg ordered) u	nfil "later"	1			1	1.
			. I				
Revie	w of the facility's police	V Medication Error	, A1			1.	
Kep	orting' revealed, "Pro	cedures: a in the	. 1				
imm	of a significant medic	ation error					
1	ediate action is taken	, as necessary, to					
		No. 1	3		1		20 00 I I I I

MS-2567(02-99) Previous Versions Obsolete

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 33 of 43

IND PLAN	ERS FOR MEDICARI NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)	MULTIPLE	CONSTRUCTION	OMB NO	D: 05/17/20 MAPPROV D: 0938-03
			A. BI	JILDING	- GONSTRUCTION	(X3) DATE S	SURVEY
NAME OF	PROVIDER OR SUPPLIER	445476	B. W	ING		1	
HILLCR	EST HEALTHCARE SO			1736	ADDRESS, CITY, STATE, ZIP C	05/0 ODE	06/2011
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		KNO	XVILLE, TN 37920		
TAG	REGULATORY OR LE	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
r d dr	protect the resident's attending physician's orders are	ge 33 s safety and welfare. b. The s notified promptlyc. The e implemented, and the I closely for 24 to 72 hours as	F3	333			
i i i i	administered a 1 ml ( (morphine) at 7:00 a.i February 22, 2011, (ir by the physician). Into DON joined the intervi-	20 mg) amount of MSO4 m., and 11:00 a.m., on estead of the 2 mg ordered erview continued, after the ew, and LPN #1 stated no ed the 1.0 ml amount was			,		
	nterview on May 4, 20	/A <b>₽</b> D					

CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 34 of 43

TATEME	NT OF DEFICIENCE						227 32750.724 14			FOR	D: 05/17/ M APPRO
MD PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULT		ONSTRUCTIO	ON		10	X3) DATE	O. 0938-( SURVEY LETED
VAME OF	PPO) (IDEA	445476	B. W	VING_					- 1		
	PROVIDER OR SUPPLIER			Terr	EET A	000000				05/	06/2011
IILLCK	EST HEALTHCARE SO	DUTH		17	758 HI	DDRESS, CIT	Y, STATE R <b>IVF</b>	ZIP COD	E		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		K	XON	VILLE, TN	37920				
PREFIX TAG	REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREI TAC	FIX			R'S PLAN	O THE AL			COMPLETE DATE
F 333	- ontainaca i folli pan	ie 34									
	On February 22 204	4 !	F:	333						31	
İ	instead of the ordere	d 100 mg of morphine		- 1							
ļ	3.00 a.m., 5:00 a.m.,	7:00 a.m., and 11:00 a.m.,									
- 1	The Immediate Jeons	and a								9	
Wa	February 22, 2011, th	rough May 6, 2011, and	1								
	Allegation of Commit	6, 2011. An acceptable	14	- 1							
i i	mmediacy of the icon	ice, which removed the									
0	corrective actions were	e validated on site by the									
fa	survey team on May 6	e validated on site by the , 2011 through review of								1	
0	bservations The sun	in interviews, and				20					
a	llegation of compliance	ce by:		1							
1.	) Verifying one nume									1	
m	edication error was n	e involved in the significant o longer employed by the		1							
in	cility; and verified the	o longer employed by the other remaining nurse	60 TO								
be	en counseled and ad	medication error had				520					
me	edication administration	ucated regarding									
ret	turn demonstration of	medication administration		1			d				
of I	Nursing on site at the	y 6, 2011. The Director									
res	igned without notice	start of the survey had	* *	1							
	erim Director of Nursin May 4, 2011.	ng had been established									
	1	· ·									- 1
2.)	Verifying all liquid nar	rcotics records were				88					
											- 1
		d Nurse on May 4, 2011	1			27					- 1
1 / 10111	III II DU AUCH I RECORDE A	nd 4h - 81						51 IS			*
							% - 10				
obse	cted. In addition the servation of liquid narco	urveyors conducted	1	- 3							- 1
1	7-14100	administration on				NO 00 II					- 1

	ERS FOR MEDICAR  NT OF DEFICIENCIES  OF CORRECTION				FOR	D: 05/17/201 M APPROVE
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	<u>). 0938-039</u> SURVEY
		445476	A. BUILDING B. WING		COMP	LETED
	PROVIDER OR SUPPLIER		B. WING_		1	2020000
HILLCR	EST HEALTHCARE S	оитн	STRE 175	ET ADDRESS, CITY, STATE, ZIP COI 88 HILLWOOD DRIVE		06/2011
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	KN	OXVILLE, TN 37920		
TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	RECTION SHOULD BE	(X5) COMPLETION
F 333				DEFICIENCY)	PPROPRIATE	DATE
1 333	Continued From pag May 6, 2011.	ge 35	F 333			
I a I i i i i i i i i i i i i i i i i i	to be initiated on ever after a medication em Physician, Director of Administrator after a re- lotification of revision addressing the change arcotics requiring ver- vo nurses if the amou- less than 5 milliliters. The facility's Audit Fornal producted daily through accreased to two times arough July 19, 2014	of the medication policy of administration of liquid ification and signatures by int to be administered is The survey team verified in for Medication Error ay 5, 2011 and be h May 19, 2011 then weekly for two months				
Se 4.)	rvices.  The survey team ve	rified the facility's plan of gistered Nurse for a two		a a a a a a a a a a a a a a a a a a a		

AND PLAN	ERS FOR MEDICAR  TOF DEFICIENCIES OF CORRECTION	TH AND HAMAN SERVICES  RE & MEL JD SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MUI TIPI E	CONSTRUCTION	FOR	D: 05/17/2 M APPROV D. 0938-0:
		TOATION NUMBER:	A. BL	IILDING	CONSTRUCTION	(X3) DATE	SURVEY
NAME OF	PROVERSE	445476	B. W			COMP	ETED
ùu Lon	PROVIDER OR SUPPLIER					05/	06/2011
HILLCR	EST HEALTHCARE S	HTUO		1758 F	ADDRESS, CITY, STATE, ZIP CODE	307	00/2011
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		KNOX	(VILLE, TN 37920		
TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	CTION OULD BE	(X5) COMPLETIO
F 333	Continue				DEFICIENCY)	ROPRIATE	DATE
	Continued From pa	ge 36	1				
	to verify alert chartir The survey team ve Regional Director of a compliance review	ng compliance for 72 hours. rified the facility's plan for the Clinical Services to perform	F 3	33	200		
i f	and related data wee monitoring time. The acility's plan to releve	ekly until the end of the esurvey team verified the			9		
fo te	nonthly through the or review and recom	end of the monitoring time mendations. The survey			*		
A   de   pl	ssurance Performanetermine if any revises.  The support to	nce Improvement committee ions are needed to the audit			*		
mi Me Ma	provement committed in the committed in	ee consist of, at a strator, Director of Nursing, Dietary, Activities,					
	mady departing	nents.				18	
Nor mor requ	n-compliance contin nitoring of corrective uired to submit a pla	ues at a "D" level for actions. The facility is n of correction.	\$ p				
C/O #	<sup>‡</sup> 27994				× 8		- 1
1 483. E SPR	65 INFECTION CO EAD, LINENS	NTROL, PREVENT	F 441				
The i	acility must establis	h and maintain an n designed to provide a		F441 1. The si	mall refrigerator was removed	from	
to hel	p prevent the development and infection.	rtable environment and opment and transmission		Manager	nent Director.		
	ootion O	N		n 5/4/11	the lift slings hanging on the	walls of	
(a) Inf	ection Control Progr cility must establish	ram an Infection Control	1 4	ic solica	side of the laundry room were by Facilities Management Di		

	ERS FOR MEDICAL				±:	FOR	D: 05/17/2 M APPROV
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	OWR MC	<u>). 0938-0</u>
			A. BUII		[0	(X3) DATE:	SURVEY
		445476	B. WIN			CONT	-CIED
NAME OF	PROVIDER OR SUPPLIEF	110470	J. 77111	<u> </u>		^ %	
HILLCE	REST HEALTHCARE :			STREET AL	DRESS, CITY, STATE, ZIP CODE	05/	06/2011
	JANOANE :	SOUTH	- 1	1120 UII	TWOOD DRIVE		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		KNOXV	ILLE, TN 37920		
TAG	REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING WERE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION	201	
		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG				COMPLET
				,	ROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE	DATE
F 441	Continued From pa	age 37					
	Program under whi	ich it	F 44	1			
	(1) Investigates co	ntrols, and prevents infections		2. The	laundry area was reconfigured by	v the	
	in the facility;	ndois, and prevents infections	1	racilit	les Management Director on 5/4/	111 to	
	(2) Decides what no	ocedures, such as isolation,		allows	folled linen to enter through a con	anrata	j
i	should be applied to	ocedures, such as isolation, o an individual resident; and		uooi wa	y, preventing crossing of soiled.	and	
	(3) Maintains a reco	ord of incidents and corrective		Clean I	mens during transport. A door no	337	
1	actions related to in	fections.		launder	es the soiled and clean areas of the	he	
- !	(h) Proventing a			affected	No residents were identified to	be	
- [	(b) Preventing Sprea	ad of Infection		anceice	<u>†</u>	1	
- 1	(1) When the Infection	on Control Program		3. All n	ursing, dietary, activities, social		
j	prevent the spread of	sident needs isolation to		services	s, housekeeping, laundry, facilitie		
11	isolate the resident	infection, the facility must		manage	ment, and administrative staff ha	S	
- 10	(2) The facility must	a L 'I ''		inservic	ed by Administrator, Interim Dir	is been	
19	communicable disea	se or infected skin lesions		of Nurs	ing, Regional Director of Clinica	CCIO	
1	rom direct contact w	ith residents or their food, if		Services	s, racilities Management assistan	ot on	
10	lirect contact will tran	ismit the disease		3/3/11 -	3/24/11 regarding this change in	. 1	
h	o) The facility must re	equire staff to wash their		uanspor	Tot soiled and clean linens All n	1011/	
l b	and washing in it	equire staff to wash their	1	chiptoye	es will be trained in laundry tran	sport	
D	and washing is indicated to the control of the cont	ated by accepted		protocol		• 1	
1.	Practice.		0.0	1 Daniu			
(0	) Linens	5		complete	ning 5/25/11 a daily audit will be	e	
Pe	ersonnel must handle	e store pre-		or Mana	ed by Facilities Management Dire	ector	
		o prevent the spread of		times a v	ger on Duty for two weeks then t week for three months and/or 100	hree	
inf	ection.	- Freed of		compliar	it with proper transport of clean a	1%	
1 -		1		soiled lin	ens to the laundry.	and	
1		E			*		
Thi	is REOLUDES			All audi	t results will be reported by the		
by:	ONL WOIKEMENT	s not met as evidenced	1	racilitie	s Management Director to the		
				monthly	Quality Assurance Performance	.	- 1
faile	ed to ensure the con	and interview, the facility aration of soiled and clean		Improve	ment meetings for review and		
area	as in the laundry roo	aration of soiled and clean		recomm	endations.	1	
			10.0	THIS CON	nmittee will determine if any		- I
one	of one laundry room	. drid solled linen for		1011210118	are needed to the audit plan.		
1				**			1
ine	findings included:						
2567/02 0	(0) Proof				= 4. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.		- 1
	9) Previous Versions Obsole	Event ID: ZTPW11	Facility II		Land the second	· 1	

STATEM	ERS FOR MEDICAR		The second		FOR	D: 05/17/20 M APPROV
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	OMB NO	O. 0938-03
			A. BUILD	DING	COMP	(X3) DATE SURVEY COMPLETED
		445476	B. WING			
NAME OF	F PROVIDER OR SUPPLIER				05/	06/2011
HILLCI	REST HEALTHCARE S	боитн	s	TREET ADDRESS, CITY, STATE, 1758 HILLWOOD DRIVE	ZIP CODE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		KNOXVILLE, TN 37920		
PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T	O THE APPROPRIATE	(X5) COMPLETION
F 441	Continui			DEFICIE	NCY)	J OATE
1 341	Continued From pa	ige 38	F 441			
	Observation of the		1 44	The Quality Assurance Pe	erformance	
	of Maintenance	laundry room with the Director		Improvement Committee	consists of	İ
				Administrator, Medical D	irector	1
				Director of Nursing, Assis	stant Director of	
				Nursing, Human Resource	es MDS Treatment	
4				Nurse, Admissions Direct	or Business Office	
				Manager, Rehab Manager	Medical Records	
	linen harrals and	or opening where the soiled		Social Services, Facilities	Management	
	Observation	ne laundry room. Continued		Director, Dietary Manager	and Activity	
1	Would roll within	the soiled linen barrels		Director. Dietician and Ph	armacist reports	
				reviewed, and these consu		. 1
- 1	Continued observer	rought into the laundry room.	0.000	needed.	itants attend as	5/26/11
- 1	Continued observation	on revealed a small	39	modeld.		12911
	The second second second	n o toble feet			"	
	four close life at	ued observation revealed	4	55	1	
			1			
				3 3		
- 1	touching the soiled ba	arrels.	1	#1		
1	Interview in the L		77	*		
1 6	Interview in the laund	ry room with the		100	1	
	THE PROPERTY OF	00 1/0 0 0044		**	ε .	
			. 1	E.,	* :	
ITO	olding table to gain er	ntry to the laundry room;				
			1	*	N 1	
				100		
			1.	100		
				e		
10.77	Trong of Solled and	clean linens				
190 40	10.70 EFFECTIVE	1		F490		
8=J   A[	DMINISTRATION/RF	SIDENT WELL-BEING	F 490	1. Immediately upon notifi	cation to the	
				Administrator on 3/4/11 by	Director of	- 1
A	facility must be admir	nistered in a manner that		Nursing of medication erro	Director of	
, 0	anico il lo age ils leci	DUITCAS Officativalis		on 2/22/11, Administrator	which occurred	-
	CICION IO ANAIN AF M	aintain the List		of Nursing on 2/4/11	Director	
pra	acticable physical ma	ental, and psychosocial		of Nursing on 3/4/11 on the	Policies and	
we	ll-being of each resid	and psychosocial		Procedures for narcotic cou of change, and the incident	ints, notification	
	S or earli lesig	CT 11	- 1	ULUMBER AND The incident	event	- 1

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 39 of 43

#### DEPARTMENT OF HEALTH AND P' AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/17/2011 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445476 B. WING NAME OF PROVIDER OR SUPPLIER 05/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE HILLCREST HEALTHCARE SOUTH 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 490 | Continued From page 39 All licensed nurses were educated by Regional Director of Clinical Services, F 490 Director of Nursing and Admissions Nurse on 5/4/11 - 5/20/11 on the following This REQUIREMENT is not met as evidenced requirements: verification of any liquid narcotic less than 5 mls by a second nurse Based on medical record review, review of facility who must also initial Medication documents, review of facility policy, review of Administration Record. Inservices also narcotic count sheets, and interview, the facility included the Five Rights of Medication Administrator failed to ensure the safe Administration, alert charting to be initiated administration of medications; failed to ensure a on every shift for seventy-two hours after a comprehensive investigation of an inaccurate medication error, timely notification of the narcotic reconciliation; failed to ensure the Physician, Director of Nursing and the physician was notified of significant medication Administrator after a medication error. еггогs; and failed to ensure a comprehensive investigation of significant medication errors for The Medical Director and Pharmacy one (resident #20) of thirty-one resident reviewed. Consultant will be advised by the The facility's failure was likely to cause serious Administrator or the Director f Nursing of injury, harm, impairment or death to resident #20. any medication administration error and will be included in the investigation process The Administrator and Corporate Nurse through the Quality Assurance Performance Consultant were informed of the Immediate Improvement process. Jeopardy on May 4, 2011, at 12:05 p.m., in the Administrator's office. 4. Daily monitoring by a Registered Nurse for two weeks, beginning May 5, 2011 The findings included: through May 19, 2011, then two times a week for three months until August 18, 2011 and/or Interview with the Administrator in the until 100% compliant, to include a 100% Administrator's office on May 4, 2011 at 9:45 audit of Medication Error Sheets for proper a.m., verified the Administrator was aware of the notification of Physician, Administrator, and significant narcotic medications errors (no date

MS-2567(02-99) Previous Versions Obsolete

known but shortly after the errors) and confirmed

administration of medications for resident #20;

did not ensure a comprehensive investigation of

February 22, 2011; did not ensure the safety of

resident #20 after a significant medication error;

significant medication error for resident #20; and

did not ensure the physician was notified of a

the Administrator did not ensure the safe

of an inaccurate narcotic reconciliation on

Event ID: ZTPW11

Facility ID; TN4706

If continuation sheet Page 40 of 43

Director of Nursing; a 100% audit of the

nurses verifying the dose and signing the

auditing of the alert charting log against the

Medication Administration Record; and

medication error reports to verify alert

charting compliance for 72 hours.

residents receiving liquid narcotic doses less

than 5 milliliters to ensure compliance of two

Medication Administration Records of

# DEPARTMENT OF HEALTH AND H' \N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIED    Complete   Construction   Complete	VO. 0938-0	OMB NO	TIPLE CONTOURNE	(X2) MIII	(X1) PROVIDER/SUPPLIER/CLIA	N OF CORRECTION	AND PLAN
MAME OF PROVIDER OR SUPPLIER  HILLCREST HEALTHCARE SOUTH  SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  F 490  Continued From page 40 (did not ensure a comprehensive investigation of a significant medication error for resident #20.  REFER TO F - 157 for failing to notify the physician REFER TO F - 281 for failing to take professional responsibility to fully investigate significant medication errors  REFER TO F - 333 for failing to prevent significant narcotic medication errors  The Immediate Jeopardy was effective from February 22, 2011, through May 6, 2011, and was removed on May 6, 2011. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated on site by the survey team on May 6, 2011 through review of facility documents, staff interviews, and observations. The survey team verified the allegation administration and had completed return demonstration of medication error had been counseled and educated regarding medication administration and had completed return demonstration of medication administration of fliquid narcotics on May 6, 2011. Through review of facility and verified the other remaining nurse involved in the significant medication administration of fliquid narcotics on May 6, 2011. Through review of facility and verified the other remaining nurse involved in the significant medication administration of fliquid narcotics on May 6, 2011. The Director of Nursing on site at the start of the survey had resigned without notice on May 4, 2011 and an interim Director of Nursing had been extended to the monthly Quality Assurance Performance Improvement meetings for review and review of 100% of May 4, 2011.  2) Verifying all limited perceits as a stabilished on May 4, 2011.	ESURVEY	(X3) DATE S		t t	IDENTIFICATION NUMBER:		
STREET ADDRESS, CITY, STATE, 2IP CODE TASS HILL WOOD DRIVE KNOXVILLE, TN 37920	PLETED	COMPL		1 *	445476		
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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
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100	hysician, Director of I	Vursing and the		Manager, Medical Record	ds Social Services	
				Facilities Management D	irector, Dietary	
				Manager, and Activity Di	rector Dietician and	
			**	Pharmacist reports are re-	viewed, and these	-1.1
		ication and signatures by to be administered is		consultants attend as need	led.	5/26/11
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MS-2567(02-99) Previous Versions Obsolete

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 42 of 43

#### DEPARTMENT OF HEALTH AND H **IN SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/17/201 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445476 B. WING NAME OF PROVIDER OR SUPPLIER 05/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE HILLCREST HEALTHCARE SOUTH 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 490 Continued From page 42 Director of Nursing; a 100 % audit of the F 490 Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports to verify alert charting compliance for 72 hours. The survey team verified the facility's plan for the Regional Director of Clinical Services to perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time. The survey team verified the facility's plan to relay results to the Quality Assurance Performance Improvement committee monthly through the end of the monitoring time for review and recommendations. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee determine if any revisions are needed to the audit plan. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee consist of, at a minimum, the Administrator, Director of Nursing, Medical Director, and Dietary, Activities, Maintenance, Business office, Social Services, and Pharmacy departments. Non-compliance continues at a "D" level for monitoring of corrective actions. The facility is required to submit a plan of correction.

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C/O #27994

Event ID: ZTPW11

Facility ID: TN4706

If continuation sheet Page 43 of 43